FORM **MEPS-10**

U.S. DEPARTMENT OF COMMERCE BUREAU OF THE CENSUS ACTING AS COLLECTING AGENT FOR U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

MEDICAL EXPENDITURE PANEL SURVEY (INSURANCE COMPONENT)

ESTABLISHMENT QUESTIONNAIRE

RETURN TO Bureau of the Census 1201 East 10th Street Jeffersonville, IN 47132-0001

If you have any questions concerning this survey, please call

Please correct errors in name, address, and ZIP Code. ENTER number and street if not shown.

A FEW IMPORTANT INSTRUCTIONS AND DEFINITIONS

- 1. For this survey, a **health insurance plan** is defined as providing **hospital and/or physician coverage** for a **single premium** to employees and/or retirees. Exclude extra-cash plans (a specified number of dollars per day in the hospital) or dread-disease (e.g., cancer-only) plans.
- 2. Coverage could have been purchased from an insurance company, provided by a union or trade association, or self-insured by your company.
- **3. Single and family** plans offered by the same insurance company and providing the same level of hospital and physician benefits count as **one plan**.
- 4. High and low options of a plan offered by the same insurance company count as two plans.
- 5. An HMO and a conventional plan offered by the same insurance company count as two plans.
- **6.** If your company operates at more than one location, provide information for the **location on the label** unless otherwise directed.
- 7. Count owners and officers as employees in the enrollment questions if they were eligible for coverage along with the other employees at this location.
- 8. For the deductibles, copayments, and premiums, report for typical situations and enrollees. If cost varies by family size, use a **family of four**. If cost varies by age, provide the information for the average age of your workers.
- 9. Estimates are acceptable if you do not have this information readily available.
- **10.** Provide information for the **pay period that included July 1, 1996** for characteristics such as coverage, premiums, and enrollment. Annual totals, such as costs, should be for **calendar year 1996**, if possible, or for the plan year that included July 1, 1996.

	Section A – NUMBER OF PLANS							
A 1.	Did you make available or contribute to the cost of any health insurance plans for your employees or retirees on July 1, 1996? See instructions 1–5 above for a description of health insurance plans.							
	1 ☐ Yes	2 □ No − If No, go to Section D on page 5.						
	Continue with S	Section B on page 2.						

	Section B – PLAN (CHARAC	TERISTICS		
B1.	On July 1, 1996, what was the name of the health insurance plan with the highest enrollment and its carrier? If you have received Supplemental Sheets (Form MEPS-10(S)) with plan names preprinted in Question B1, answer only for the preprinted plans. Otherwise, provide data for your 4 largest plans. You may make a copy of the Supplemental Sheet, or Section B of this form, if necessary.	B5c.	off	ar that includ istrative cost mployer and this is the onl	led July 1, 1996. s, and stop-loss employee y plan you ter this amount
	FOR CENSUS USE ONLY				
100 012 Nam	e of plan	d.	Enter the monthly premiu COBRA amount if premium calculated) for single and fa a typical full-time employee in B5c. Also enter this infor	equivalents amily (of four e. Include the	were not) coverage for costs entered
l luin		109	(single) and B11b (family) -	- Total premi	um on page 3.
¹⁰² Nam	e of insurance carrier	110	\$.00 Sir	ngle coverage)
B2.	Indicate the type of providers in this plan.		\$.00 Fai	mily coverage	Э
103	1 Exclusive providers – Enrollees must go to providers associated with the plan except in an emergency. There is typically no cost or a small fixed cost for each physician visit. (For example, HMOs, IPAs, EPOs)		Is the amount entered in B5 1 A premium equivalent? 2 A COBRA amount?		
	Any providers – Enrollees can go to the physicians of their choice on a fee-for-service basis. The plan does not have any associated providers. (For example, conventional plans, indemnity plans) 3 Mixture of preferred and any providers – Enrollees can go to a set of "preferred" providers associated with the plan, or providers of their		If self-insured, go to Que		
			Was this plan purchased th with other employers such (MET) or a multi-employer 1 ☐ Yes 2 ☐ No	as a multi-en	nployer trust
	choice. If they go to a non-preferred provider, they face higher costs. (For example, PPOs, POSs)	B7.	Was this plan operated by a	 a _	
В3.	Did this plan require that the enrollee see a primary-care physician in order to be referred to a specialist?	113	1 ☐ Union ⊋ 2 ☐ Trade	Association ,	⊋ 3 ☐ Neither
104	1 □ Yes 2 □ No	114 Name	of union or trade association	۱ 1	¹⁵ Local number, if a union
B4.	Indicate the type of indemnification of this plan.	¹¹⁶ Name	of insurance representative		
105	Purchased from an insurance underwriter – Coverage is purchased from an insurance company or other underwriter who assumes the risk for		·		
	enrollees' medical expenses. If purchased, go to Question B6.	117 Addre	ss (Number and street)		
	 Self-insured – Your company pays the claims from its resources and may charge a premium to employees. The plan may be administered by a third 	¹¹⁸ City		¹¹⁹ State	120 ZIP Code
	party. This type may employ supplemental stop-loss insurance to limit unanticipated losses.	¹²¹ Teleph	one number		
	For self-insured plans only:	()		
B5a.	Indicate if you administered the plan or if you employed a third party.	B8.	Did any enrollee receive a contribution towards any p (e.g., from a union or gover	art of the pre	
106	1 ☐ Self-administered 2 ☐ Insurance company or other administrator	122	1 Yes 2 No		
b.	Did you purchase stop-loss coverage?	B9.	In what month did the plan Enter a numeric response	year begin?	
107	1 ☐ Yes 2 ☐ No		(e.g., Jan = 01, May = 05).		Month

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	Section B - PLAN CHARACTERISTICS - Continued					
B10a.	For this plan, enter the total number of enrollees excluding dependents for this establishment on July 1, 1996.	B12b.	Did the amount of the employee contribution (not premium) vary for different employee categories (e.g., full-time, part-time, retiree)?			
		143	1			
b.	Enter the total number of active employees enrolled.	B13.	Did this plan's premium include either of these services? Check all that apply.			
		144	☐ Life insurance 145 ☐ Disability insurance			
C.	Enter the number of former employees enrolled through COBRA or other State continuation-of-benefits laws.	B14.	Enter the annual deductibles that enrollees paid out of their pockets before the plan began paying for covered services (using the plan's providers). Many HMO-type plans do not have deductibles.			
d	Enter the number of retirees enrolled.	140	\$.00 Total individual annual deductible OR $ abla$			
127	128 65 and		Separate deductibles for:			
	Total older		147			
e.	Enter the total number of enrollees with single coverage.		\$.00 Physician care			
129			\$.00 Hospital care			
			If the deductible is per overnight hospital stay,			
R11a	Enter this plan's total premium, employer contribution,		report under B15a.			
Dira.	and employee contribution for a typical full-time	149	\$.00 Total family annual deductible (if applicable)			
	employee with single coverage. If self-insured, enter the monthly premium equivalent from Question B5d on page 2.	150	Number of persons – Enter if the plan also specified that the family deductible was met when a number of family members fulfilled			
130	00		their individual deductibles.			
101	\$.00 Total premium	151	Plan did not have a deductible			
131	\$.00 Employer contribution	B15a.	How much did an enrollee pay for an overnight hospital stay (in a participating hospital, if applicable) after any annual deductible was met?			
	\$.00 Employee contribution	152	154 1 ☐ Per day			
122	Indicate the premium period		\$.00 Per stay			
133 b.	1	153	OR Percent OR			
	employee contribution for an enrolled family (of four).	155	☐ Hospital care was not covered			
	Report for the same premium period as in Question B11a.	_				
134	If self-insured, enter the monthly premium equivalent from Question B5d on page 2.	b.	How much did an enrollee pay for an office visit (with a participating physician, if applicable) after any annual deductible was met?			
	\$.00 Total premium	156	\$.00			
135	\$.00 Employer contribution		OR			
136	\$.00 Employer contribution	157				
	\$.00 Employee contribution		Percent OR			
137	☐ Family coverage was not offered	218 	Physician care was not covered			
B12a.	Did the premiums (not contributions) vary by –	B16.	What was the maximum amount this plan would have paid for an individual –			
138	Check all that apply.	a.	Over the enrollee's lifetime?			
139	☐ Age? ☐ Sex?	159	\$.00			
140	☐ Number of persons (within family coverage)?	b.	In one year?			
141 142	☐ Wage or salary levels?☐ Other? – <i>Specify</i>	160	iii one year:			
099	Guier: - Specify		\$.00			
		158	☐ No maximum			

Section B – PLAN CHARACTERISTICS – Continued						
B17.	What was the maximum annual out-of-pocket amount for –	B19.	Could this plan have refused to cover persons with certain preexisting conditions?			
	An individual?	183	1 ☐ Yes $ ot Z ot$ No			
161	\$.00	104	Did this happen in 1996?			
b.	A family (of four)?	184	1 Yes 2 No			
162	\$.00	B20.	Could this plan have imposed a waiting period for persons with certain preexisting conditions?			
163	☐ No maximum	185	1 Yes 2 No			
B18.	Indicate which of these services were included in the plan.	B21a.	Is this plan offered in 1997?			
2.0.	Check all that apply.	186	1 Yes – If Yes, go to Question B21c.			
164	Routine mammograms	b.	If it is not still offered, indicate if it has been –			
165 166	☐ Adult routine physical exams ☐ Routine pap smears	187	1 ☐ Replaced with a similar plan			
167	☐ Office visits for prenatal care		2 Replaced with a similar plan 2 Dropped without			
168	☐ Adult immunizations		offering a replacement – Go to Section C.			
169	☐ Child immunizations	C.	For 1997, enter the single and family enrollments and premiums for this plan or the one that took its place.			
170	Well-baby care, under 1 year		Report for the same premium period as in Question B11a			
171 172	☐ Well-child care, 1–4 years ☐ 100% well-baby care		on page 3.			
173		188	Single enrollment			
173	☐ Chiropractic care ☐ Other non-physician providers	189	3 ingle emolinent			
175	Outpatient prescriptions		Family enrollment			
176	Routine dental care	190				
177	☐ Orthodontic care		\$.00 Single premium			
178	☐ Nursing home care	191				
179	Home health care		\$.00 Family premium			
180		Pleas	e complete one Supplemental Sheet for each			
181	☐ Inpatient mental illness☐ Outpatient mental illness☐		ional hospital/physician plan you offered your byees and retirees on July 1, 1996. You may use			
182	☐ Alcohol/substance abuse treatment	photo	copies of the Supplemental Sheet or Section B of			
			orm, if necessary.			
	Section C – GENERAL HEALTH	COVERA	GE CHARACTERISTICS			
C1a.	Did you offer optional coverage (not included in the basic health coverage) for any of these services in 1996 at an additional premium to the employee?	C2a.	Did you impose a waiting period before new employees could be covered by health insurance?			
	Check all that apply.	197	1 ☐ Yes $ ot Z ot$ No			
192	☐ Dental	b.	What was the typical waiting period?			
193	☐ Vision	198	1 Less than 2 weeks			
194	Prescription drugs		2 2 weeks to less than 1 month			
195	☐ Long-term care		3 ☐ 1–3 months 4 ☐ More than 3 months			
b.	What was the total amount paid for these coverages in 1996? <i>Include employer and employee contributions.</i>	C3.	Enter the total annual cost of coverage for the plan year			
196	00		that included July 1, 1996 for ALL hospital/physician plans that you offered at this location . <i>Include</i>			
	\$.00	199	employer and employee contributions.			
		199	\$.00			

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	Section D - EMPLOYMENT CHARACTERISTICS						
D1.	Enter the number of employees on your payroll at the location printed on the label for each of the categories below. Report for the pay period that included July 1, 1996.	D2.	For the pay period that included July 1, 1996 –				
	If you offered health insurance, also enter the number of employees eligible and enrolled for coverage through your organization. Include officers and owners. Exclude	a.	employees				
	leased, contract or agency workers.	b.	Enter the number of employees 50 years old or older				
a.	All employees		Enter the number of employees				
200	Total Eligible Enrolled	.	who were union members				
		d.	Enter the number of employees who earned –				
b.	Part-time employees		042				
203	Total Eligible Enrolled		(1) Less than \$6.50 per hour				
			(2) Between \$6.50 and \$15.00 per hour				
C.	Temporary (seasonal) employees		(2) Mars than \$15.00 year have				
206	Total Eligible Enrolled		(3) More than \$15.00 per hour				
_		D3.	How many hours per week must an employee work to be considered full time at your establishment?				
d.	Were retirees eligible to receive health insurance (other than through COBRA or other continuation-of-benefits	041					
219	laws) on July 1, 1996?		Hours				
210	1 ☐ Yes – Check all that apply 2 ☐ No						
	209 Retirees under 65 years 210 Retirees 65 years and over						
	☐ hetirees of years and over						
	Section E - COMPAN	Ү СНА	RACTERISTICS				
E1.	Do you offer any of these fringe benefits?	Y CHAI	RACTERISTICS Which of these categories best describes your principal business activity?				
E1.		·	Which of these categories best describes your principal				
050	Do you offer any of these fringe benefits? Check all that apply. Paid vacation	·	Which of these categories best describes your principal business activity? Check only ONE. 1 Retail trade				
	Do you offer any of these fringe benefits? Check all that apply. Paid vacation Paid sick leave	E4.	Which of these categories best describes your principal business activity? Check only ONE. 1 Retail trade 2 Personal services (e.g., beauty shops, dry cleaners)				
050 051	Do you offer any of these fringe benefits? Check all that apply. Paid vacation Paid sick leave Life insurance	E4.	Which of these categories best describes your principal business activity? Check only ONE. 1 Retail trade 2 Personal services (e.g., beauty shops, dry cleaners) 3 Business services (e.g., advertising, computer				
050 051 052	Do you offer any of these fringe benefits? Check all that apply. Paid vacation Paid sick leave	E4.	Which of these categories best describes your principal business activity? Check only ONE. 1 Retail trade 2 Personal services (e.g., beauty shops, dry cleaners)				
050 051 052 053 054 055	Do you offer any of these fringe benefits? Check all that apply. Paid vacation Paid sick leave Life insurance Disability insurance Retirement/pension plans Medical Savings Accounts (MSAs)	E4.	Which of these categories best describes your principal business activity? Check only ONE. 1 Retail trade 2 Personal services (e.g., beauty shops, dry cleaners) 3 Business services (e.g., advertising, computer processing) 4 Other services (e.g., legal and health services) 5 Manufacturing				
050 051 052 053	Do you offer any of these fringe benefits? Check all that apply. Paid vacation Paid sick leave Life insurance Disability insurance Retirement/pension plans	E4.	Which of these categories best describes your principal business activity? Check only ONE. 1 Retail trade 2 Personal services (e.g., beauty shops, dry cleaners) 3 Business services (e.g., advertising, computer processing) 4 Other services (e.g., legal and health services) 5 Manufacturing 6 Wholesale trade				
050 051 052 053 054 055	Do you offer any of these fringe benefits? Check all that apply. Paid vacation Paid sick leave Life insurance Disability insurance Retirement/pension plans Medical Savings Accounts (MSAs)	E4.	Which of these categories best describes your principal business activity? Check only ONE. 1 Retail trade 2 Personal services (e.g., beauty shops, dry cleaners) 3 Business services (e.g., advertising, computer processing) 4 Other services (e.g., legal and health services) 5 Manufacturing 6 Wholesale trade 7 Finance, insurance, or real estate				
050 051 052 053 054 055	Do you offer any of these fringe benefits? Check all that apply. Paid vacation Paid sick leave Life insurance Disability insurance Retirement/pension plans Medical Savings Accounts (MSAs) Flexible spending accounts Cafeteria plan - Enter the average	E4.	Which of these categories best describes your principal business activity? Check only ONE. 1 Retail trade 2 Personal services (e.g., beauty shops, dry cleaners) 3 Business services (e.g., advertising, computer processing) 4 Other services (e.g., legal and health services) 5 Manufacturing 6 Wholesale trade				
050 051 052 053 054 055	Do you offer any of these fringe benefits? Check all that apply. Paid vacation Paid sick leave Life insurance Disability insurance Retirement/pension plans Medical Savings Accounts (MSAs) Flexible spending accounts Cafeteria plan – Enter the average annual value per	E4.	Which of these categories best describes your principal business activity? Check only ONE. Retail trade Personal services (e.g., beauty shops, dry cleaners) Business services (e.g., advertising, computer processing) Other services (e.g., legal and health services) Manufacturing Wholesale trade Finance, insurance, or real estate Transportation, communications, electric, gas, or sanitary services Construction				
050 051 052 053 054 055 056	Do you offer any of these fringe benefits? Check all that apply. Paid vacation Paid sick leave Life insurance Disability insurance Retirement/pension plans Medical Savings Accounts (MSAs) Flexible spending accounts Cafeteria plan - Enter the average annual value per employee * .00	E4.	Which of these categories best describes your principal business activity? Check only ONE. Retail trade Personal services (e.g., beauty shops, dry cleaners) Business services (e.g., advertising, computer processing) Other services (e.g., legal and health services) Manufacturing Wholesale trade Finance, insurance, or real estate Transportation, communications, electric, gas, or sanitary services Construction Agriculture or forestry				
050 051 052 053 054 055	Do you offer any of these fringe benefits? Check all that apply. Paid vacation Paid sick leave Life insurance Disability insurance Retirement/pension plans Medical Savings Accounts (MSAs) Flexible spending accounts Cafeteria plan – Enter the average annual value per	E4.	Which of these categories best describes your principal business activity? Check only ONE. Retail trade Personal services (e.g., beauty shops, dry cleaners) Business services (e.g., advertising, computer processing) Other services (e.g., legal and health services) Manufacturing Wholesale trade Finance, insurance, or real estate Transportation, communications, electric, gas, or sanitary services Construction				
050 051 052 053 054 055 056	Do you offer any of these fringe benefits? Check all that apply. Paid vacation Paid sick leave Life insurance Disability insurance Retirement/pension plans Medical Savings Accounts (MSAs) Flexible spending accounts Cafeteria plan - Enter the average annual value per employee Which of these categories best describes your type	E4.	Which of these categories best describes your principal business activity? Check only ONE. Retail trade Personal services (e.g., beauty shops, dry cleaners) Business services (e.g., advertising, computer processing) Other services (e.g., legal and health services) Manufacturing Wholesale trade Transportation, communications, electric, gas, or sanitary services Construction Agriculture or forestry Mining Public administration				
050 051 052 053 054 055 056	Do you offer any of these fringe benefits? Check all that apply. Paid vacation Paid sick leave Life insurance Disability insurance Retirement/pension plans Medical Savings Accounts (MSAs) Flexible spending accounts Cafeteria plan – Enter the average annual value per employee employee Which of these categories best describes your type of ownership? Check only ONE. S Corporation	E4.	Which of these categories best describes your principal business activity? Check only ONE. Retail trade Personal services (e.g., beauty shops, dry cleaners) Business services (e.g., advertising, computer processing) Other services (e.g., legal and health services) Manufacturing Wholesale trade Finance, insurance, or real estate Transportation, communications, electric, gas, or sanitary services Construction Agriculture or forestry Mining Public administration How many years has your company been in business? If you operate at multiple locations, enter the number of				
050 051 052 053 054 055 056 057	Do you offer any of these fringe benefits? Check all that apply. Paid vacation Paid sick leave Life insurance Disability insurance Retirement/pension plans Medical Savings Accounts (MSAs) Flexible spending accounts Cafeteria plan – Enter the average annual value per employee employee Which of these categories best describes your type of ownership? Check only ONE. S Corporation Corporation Corporation	E4.	Which of these categories best describes your principal business activity? Check only ONE. Retail trade Personal services (e.g., beauty shops, dry cleaners) Business services (e.g., advertising, computer processing) Other services (e.g., legal and health services) Manufacturing Wholesale trade Transportation, communications, electric, gas, or sanitary services Construction Agriculture or forestry Mining Public administration How many years has your company been in business?				
050 051 052 053 054 055 056 057	Do you offer any of these fringe benefits? Check all that apply. Paid vacation Paid sick leave Life insurance Disability insurance Retirement/pension plans Medical Savings Accounts (MSAs) Flexible spending accounts Cafeteria plan – Enter the average annual value per employee which of these categories best describes your type of ownership? Check only ONE. S Corporation Corporation Partnership	E4.	Which of these categories best describes your principal business activity? Check only ONE. Retail trade Personal services (e.g., beauty shops, dry cleaners) Business services (e.g., advertising, computer processing) Other services (e.g., legal and health services) Manufacturing Wholesale trade Finance, insurance, or real estate Transportation, communications, electric, gas, or sanitary services Construction Agriculture or forestry Mining Public administration How many years has your company been in business? If you operate at multiple locations, enter the number of years in business for the entire enterprise.				
050 051 052 053 054 055 056 057	Do you offer any of these fringe benefits? Check all that apply. Paid vacation Paid sick leave Life insurance Disability insurance Retirement/pension plans Medical Savings Accounts (MSAs) Flexible spending accounts Cafeteria plan – Enter the average annual value per employee Which of these categories best describes your type of ownership? Check only ONE. S Corporation Corporation Partnership CorporationSide Accounts Check only ONE.	E4.	Which of these categories best describes your principal business activity? Check only ONE. Retail trade Personal services (e.g., beauty shops, dry cleaners) Business services (e.g., advertising, computer processing) Other services (e.g., legal and health services) Manufacturing Wholesale trade Finance, insurance, or real estate Transportation, communications, electric, gas, or sanitary services Construction Agriculture or forestry Mining Public administration How many years has your company been in business? If you operate at multiple locations, enter the number of				
050 051 052 053 054 055 056 057	Do you offer any of these fringe benefits? Check all that apply. Paid vacation Paid sick leave Life insurance Disability insurance Retirement/pension plans Medical Savings Accounts (MSAs) Flexible spending accounts Cafeteria plan – Enter the average annual value per employee which of these categories best describes your type of ownership? Check only ONE. S Corporation Corporation Partnership	E4.	Which of these categories best describes your principal business activity? Check only ONE. Retail trade Personal services (e.g., beauty shops, dry cleaners) Business services (e.g., advertising, computer processing) Other services (e.g., legal and health services) Manufacturing Wholesale trade Finance, insurance, or real estate Transportation, communications, electric, gas, or sanitary services Construction Agriculture or forestry Mining Public administration How many years has your company been in business? If you operate at multiple locations, enter the number of years in business for the entire enterprise. Years Years Years Years Transportation Years Years				
050 051 052 053 054 055 056 057	Do you offer any of these fringe benefits? Check all that apply. Paid vacation Paid sick leave Life insurance Disability insurance Retirement/pension plans Medical Savings Accounts (MSAs) Flexible spending accounts Cafeteria plan - Enter the average annual value per employee Which of these categories best describes your type of ownership? Check only ONE. S Corporation Corporation Partnership Sole Proprietorship Government (Federal, state, or local)	E4. 060 E5.	Which of these categories best describes your principal business activity? Check only ONE. Retail trade Personal services (e.g., beauty shops, dry cleaners) Business services (e.g., advertising, computer processing) Other services (e.g., legal and health services) Manufacturing Wholesale trade Finance, insurance, or real estate Transportation, communications, electric, gas, or sanitary services Construction Agriculture or forestry Mining Public administration How many years has your company been in business? If you operate at multiple locations, enter the number of years in business for the entire enterprise.				

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	Section F - TO	BE COMPLETED IF YOU DID I	NOT OF	FER HEALT	H INSURANCE CO	OVERAGE
F1a.	Has your business offe benefit to the employe since January 1, 1991	ered any health insurance as a sees or retirees of this location	F3a.	provide a voi	oviding a health plan ir ucher or stipend to you d to purchase health in	r employees which
031	1 ☐ Yes	If No, go to Question F2.	045	1 ☐ Yes	2 No – If No, go	to Section G.
b.	insurance coverage to	business last offer health the employees of this location?	b.	1 🗌 Health in	ucher or stipend be us surance/health care on rposes as well?	
F2.		al or hospital bills of your	C.	What was the voucher or st		ployee of this 1 Week 2 2 weeks 3 Month 4 Year
		Section G - PERSON COMPL	ETING '	THIS QUES	TIONNAIRE	
²¹² Nam	ne (<i>Please print</i>)		²¹³ Title			
Signatu	ıre					214 Date
²¹⁵ Tele	phone number	²²⁰ Extension ²¹⁶ FAX number			²¹⁷ E-Mail address	

FORM **MEPS-10(P)**

U.S. DEPARTMENT OF COMMERCE BUREAU OF THE CENSUS ACTING AS COLLECTING AGENT FOR U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

MEDICAL EXPENDITURE PANEL SURVEY (INSURANCE COMPONENT)

PERSON-LEVEL QUESTIONNAIRE FOR ESTABLISHMENTS

Collection of this information is authorized under Title IX, Section 902(a) of the Public Health Service Act. Sections 903(c) and 308(d) of that Act specify that all information will be held in strict confidence by the staff of the Agency for Health Care Policy and Research and their authorized contractors.

RETURN TO Bureau of the Census 1201 East 10th Street Jeffersonville, IN 47132-0001

If you have any questions concerning this survey, please call

A FEW IMPORTANT INSTRUCTIONS AND DEFINITIONS

- 1. In this questionnaire, "this person" refers to the individual named in the label area. A permission slip signed by the individual authorizing our collection of this information is included at the back of this reporting package.
- 2. "Your organization" refers to the location on the label of this questionnaire.
- 3. For this survey, a health insurance plan is defined as providing hospital and/or physician coverage for a single premium to employees and/or retirees. Also included in Section C of this questionnaire are single-service plans, which provide optional coverage not included in the basic health insurance plan(s) for an additional premium.

	Section A - PERSON-LEVEL INFORMATION						
A 1.	Which category below best describes this person's status with your organization on July 1, 1996?						
065	Check only ONE.						
	A full- or part-time employee A retiree A former employee A relative/survivor of a former employee A seasonal or temporary employee An employee of a temporary agency An independent contract worker No record of this person Go to Section B on page 2. Go to Section B on page 2.						

	Section B – HOSPITAL	OR PH	YSICIAN PLAN
B1a.	Was this person eligible for hospital/physician insurance coverage through your organization on July 1, 1996?	B4b.	How much did this person contribute towards his/her coverage?
350	1 ☐ Yes 2 ☐ No – If No, go to Section C on page 3.	362	Report for the same premium period as in Question B4a.
	If more than one plan was offered through this organization, answer Part b below. If only one plan was offered, go to Question B2a.	302	\$.00 OR
b.	Of the hospital/physician plans offered by your organization, for which plans was this person eligible?	353	Percent of insurance premium
	Please enter plan name(s) exactly as entered in Question B1 of the Establishment Questionnaire (MEPS-10) or Supplemental Sheet (MEPS-10(S)).	c.	How much did your organization contribute towards this person's coverage?
351	□ All OR ≠		Report for the same premium period as in Question B4a.
501		363	
502			\$.00 OR
503		354	Percent of insurance premium
504		d.	How much did sources other than your organization, such
B2a.	Was this person enrolled in a hospital/physician plan provided by your organization on July 1, 1996?		as a union or government, contribute towards/subsidize this person's coverage?
231	1 \square Yes \nearrow 2 \square No – If No, go to Section C on page 3.	355	Report for the same premium period as in Question B4a.
	If more than one plan was offered through this organization, answer Part b below. If only one plan was offered, go to Question B3.		\$.00 OR
b.	In which hospital/physician plan(s) was this person enrolled?	356	Percent of insurance premium
	Please enter plan name(s) exactly as entered in Question B1 of the Establishment Questionnaire (MEPS-10) or Supplemental Sheet (MEPS-10(S)).	257	OR
352	□ All OR 🖟	357	No subsidy/contribution from other sources – Go to Question B6.
021	•		
505		B5.	What was the source of the outside subsidy or contribution reported in B4d?
			Check only ONE.
B3 .	What level of coverage did this person choose?	358	1 Union
239	1 ☐ Single 3 ☐ One adult/one child 2 ☐ Two adults 4 ☐ Family (3 or more people)		2 ☐ Government 3 ☐ Other
B4.	For the pay period including July 1, 1996, provide the information below regarding premiums paid for this person's hospital/physician coverage.	B6.	Was this person's insurance provided through COBRA?
a.	What was the total premium including both employer and employee contributions?	359	1 □ Yes 2 □ No
	If this plan was self-insured, enter the monthly premium equivalent. If a premium equivalent was not calculated, enter the COBRA amount.		
361	\$.00 PER \longrightarrow 376 1 \square Week 2 \square 2 weeks 3 \square Month		
	4 ☐ Year		

Page 2 FORM MEPS-10(P) (7-7-97)

Control No.

	Section C - SINGL	E-SER\	/ICE PLANS
C1.	On July 1, 1996, did this person obtain through your organization any optional coverage (not included in his/her basic health plan reported in Section B above) at an additional premium?	C3a.	What was the total premium for all single-service plans obtained by this person, including both employer and employee contributions? 380 1 ☐ Week
246 	1 Yes 2 No - If No, go to Section D.	-	\$.00 PER \longrightarrow 2 \(\sum 2\) weeks 3 \(\sum Month\) Month 4 \(\sum Year\)
	Which of the following single-service plans did this person obtain? Check all that apply.	b.	How much did this person contribute towards his/her single-service plan coverage? Report for the same premium period as in Question C3a.
370 372 371 373	□ Dental□ Vision□ Prescription drugs□ Long-term care	375	\$.00 OR
		360	Percent of insurance premium
500 Ren	narks		
	Section D - PERSON COMPL	ETING	THIS QUESTIONNAIRE
²¹² Nan	ne (Please print)	²¹³ Title	
Signatu	ıre		²¹⁴ Date
215 Tale	ephone number 220 Extension 216 FAX number		²¹⁷ E-Mail address
() ()		L Maii audiess

FORM MEPS-10(P) (7-7-97)

Page 3

FORM **MEPS-10(S)**

U.S. DEPARTMENT OF COMMERCE BUREAU OF THE CENSUS ACTING AS COLLECTING AGENT FOR U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

MEDICAL EXPENDITURE PANEL SURVEY (INSURANCE COMPONENT)

SUPPLEMENTAL SHEET ESTABLISHMENT QUESTIONNAIRE

INSTRUCTIONS

This Supplemental Sheet is a reprint of the questions in Section B of the Establishment Questionnaire (MEPS-10).

You may use it to report additional health plan information. You may use photocopies of this Supplemental Sheet if sufficient copies were not included in your reporting package. Refer to the instructions on the first page of the Establishment Questionnaire (MEPS-10) when completing this Supplemental Sheet.					
	Section B – PLAN (CHARA	CTERISTICS		
B1.	Enter the name of the health insurance plan and the insurance carrier.	_	For self-insured plans only:		
	FOR CENSUS USE ONLY	B5a.	Indicate if you administered the plan or if you employed a third party.		
100		106	1 ☐ Self-administered 2 ☐ Insurance company or other administrator		
⁰¹² Nam	e of plan	b.	Did you purchase stop-loss coverage?		
¹⁰² Nam	e of insurance carrier	107	1 ☐ Yes 2 ☐ No		
B2.	Indicate the type of providers in this plan.	C.	Enter this establishment's total annual cost of coverage for this plan for the plan year that included July 1, 1996. Include: claims paid, administrative costs, and stop-loss		
103	Exclusive providers – Enrollees must go to providers associated with the plan except in an emergency. There is typically no cost or a small fixed cost for each physician visit. (For example, HMOs, IPAs, EPOs)	108	coverage (if any). Include both employer and employee contributions. \$.00		
	2 Any providers – Enrollees can go to the physicians of their choice on a fee-for-service basis. The plan does not have any associated providers. (For example, conventional plans, indemnity plans) 3 Mixture of preferred and any providers –	d.	Enter the monthly premium equivalents (or the COBRA amount if premium equivalents were not calculated) for single and family (of four) coverage for a typical full-time employee. Include the costs entered in B5c. Also enter this information in Question B11a (single) and B11b (family) – Total premium on page 2.		
	Enrollees can go to a set of "preferred" providers associated with the plan, or providers of their choice. If they go to a non-preferred provider, they face higher costs. (For example, PPOs, POSs)	109	\$.00 Single coverage		
В3.	Did this plan require that the enrollee see a primary-care physician in order to be referred to a specialist?	. 110	\$.00 Family coverage		
104	1 ☐ Yes 2 ☐ No	e.	Is the amount entered in B5d –		
B4.	Indicate the type of indemnification of this plan.	111	1 ☐ A premium equivalent? 2 ☐ A COBRA amount?		
105	1 — Purchased from an insurance underwriter – Coverage is purchased from an insurance company or other underwriter who assumes the risk for enrollees' medical expenses.		If self-insured, go to Question B7 on page 2.		
	If purchased, go to Question B6.	B6.	Was this plan purchased through a pooling arrangement		
	2 Self-insured – Your company pays the claims from its resources and may charge a premium to employees. The plan may be administered by a <i>third party</i> . This type may employ supplemental <i>stop-loss insurance</i> to limit upanticipated losses.	112	with other employers such as a multi-employer trust (MET) or a multi-employer welfare arrangement (MEWA)? 1 \Boxed Yes 2 \Boxed No		

	Section B – PLAN CHARACTERISTICS – Continued					
B7.	Was this plan operated by a	⊋ 3 □ Neither	B11a.	Enter this plan's total and employee contrib employee with single	premium, employer contribution, ution for a typical full-time coverage.	
¹¹⁴ Name	ne of union or trade association 115 Local number, if a union			130	If self-insured, enter the from Question B5d on	ne monthly premium equivalent page 1.
¹¹⁶ Name	of insurance representative			131	\$.00	
¹¹⁷ Addres	ss (Number and street)			132		Employer contribution Employee contribution
¹¹⁸ City		¹¹⁹ State	¹²⁰ ZIP Code	133	Indicate the premium $1 \square$ Week $2 \square 2$	period ⊋ weeks 3 ☐ Month 4 ☐ Year
¹²¹ Teleph	one number			b.	and employee contrib	premium, employer contribution, ution for an enrolled family
()				(of four).	remium period as in Question B11a.
B8.	Did any enrollee receive a d contribution towards any pa (e.g., from a union or gover	art of the pre	or mium	404	•	ne monthly premium equivalent
122	1 Yes 2 No			134 135	\$.00	Total premium
B9.	In what month did the plan	year begin?		136	\$.00	Employer contribution
	Enter a numeric response (e.g., Jan = 01, May = 05).		Month		\$.00	Employee contribution
B10a.	For this plan, enter the total dependents for this establish	number of e	— — — — — — - nrollees excluding lv 1 1996	. 137	☐ Family coverage v	vas not offered
124		mione on ou	1, 1000.	B12a.	Did the premiums (n	ot contributions) vary by –
					Check all that apply.	
b.	Enter the total number of ac	ctive employ	ees enrolled.	138 139	☐ Age? ☐ Sex?	
125				140 141	☐ Number of person☐ Wage or salary let	ns (within family coverage)? vels?
				142 099	Other? - Specify	
C.	Enter the number of former COBRA or other State continuous continu	employees of the nuation-of-be	enrolled through enefits laws.			
126				b.	Did the amount of th (not premium) vary for (e.g., full-time, part-time)	ne employee contribution or different employee categories ne, retiree)?
	Enter the number of retirees			143	1 ☐ Yes	2 🗆 No
127	Total	128	65 and older	B13.	•	um include either of these services?
e. 129	Enter the total number of enrollees with single coverage.			144	Check all that apply.	¹⁴⁵ Disability insurance

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	Section B - PLAN CHARACTERISTICS - Continued						
B14.	Enter the annual deductibles that enrout of their pockets before the plan beg covered services (using the plan's provi HMO-type plans do not have deductible	an paying for ders). Many	What was the maximum annual out-of-pocket amount for – An individual?				
146	\$.00 Total individu		\$.00				
	Separate deductibles for:	b.	A family (of four)?				
	\$.00 Physician	care 162	\$.00				
	\$.00 Hospital o	103	☐ No maximum				
149	report under B15a.	B18.	Indicate which of these services were included in the plan.				
	\$.00 Total family a deductible (if	applicable) 🍃	Check all that apply.				
150	Number of persons – Enter if the specified that the family deduction when a number of family ment their individual deductibles.	ctible was met	☐ Routine mammograms☐ Adult routine physical exams☐ Routine pap smears				
151	☐ Plan did not have a deductible	167	☐ Office visits for prenatal care				
B15a.	How much did an enrollee pay for an chospital stay (in a participating hospital after any annual deductible was met?	pvernight 168 al, if applicable) 169	☐ Adult immunizations ☐ Child immunizations				
152	154 1 G	Per day 170 Per stay 171	☐ Well-baby care, under 1 year ☐ Well-child care, 1–4 years				
153	OR	172	☐ 100% well-baby care ☐ Chiropractic care				
	Percent	174 175	☐ Other non-physician providers ☐ Outpatient prescriptions				
155	☐ Hospital care was not covered	176 177	☐ Routine dental care ☐ Orthodontic care				
b.	How much did an enrollee pay for an a participating physician, if applicable) a deductible was met?	office visit (with	☐ Nursing home care ☐ Home health care				
156	\$.00	180	☐ Inpatient mental illness				
157	OR	181 182	☐ Outpatient mental illness ☐ Alcohol/substance abuse treatment				
218	Percent OR	B19.	Could this plan have refused to cover persons with certain preexisting conditions?				
	Physician care was not covered	183	1 ☐ Yes 2 ☐ No				
B16.	What was the maximum amount this pl paid for an individual –	an would have	Did this happen in 1996? 1 ☐ Yes 2 ☐ No				
a.	Over the enrollee's lifetime?						
159	\$.00	B20.	Could this plan have imposed a waiting period for persons with certain preexisting conditions?				
b.	In one year?	185	1 ☐ Yes 2 ☐ No				
160	\$.00						
158	☐ No maximum						

	Section B – PLAN CHARA	CTERIST	ICS - Continued	
B21a.	Is this plan offered in 1997?	B21c.	For 1997, enter the sin	gle and family enrollments and n or the one that took its place.
	1 Yes – If Yes, go to Question B21c. 2 No			remium period as in Question B11a
b.	If it is not still offered, indicate if it has been –	188	Sin	gle enrollment
187	1 ☐ Replaced with a similar plan 2 ☐ Replaced by a substantially different plan	189	Far	nily enrollment
	3 ☐ Dropped without offering a replacement – END THIS FORM.	190	\$.00	Single premium
		191	\$.00	Family premium
⁵⁰⁰ Remar	ks			

FORM **MEPS-11(C)**

U.S. DEPARTMENT OF COMMERCE BUREAU OF THE CENSUS ACTING AS COLLECTING AGENT FOR U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

MEDICAL EXPENDITURE PANEL SURVEY (INSURANCE COMPONENT)

GOVERNMENT/CERTAINTY QUESTIONNAIRE

Collection of this information is authorized under Title IX, Section 902(a) of the Public Health Service Act. Sections 903(c) and 308(d) of that Act specify that all information will be held in strict confidence by the staff of the Agency for Health Care Policy and Research and their authorized contractors.

RETURN TO Bureau of the Census Governments Division – MEPS Washington Plaza II, Rm. 413 Washington, DC 20233-6800

If you have any questions concerning this survey, please call 1–888–206–5068.

Please correct errors in name, address, and ZIP Code. ENTER number and street if not shown.

A FEW IMPORTANT INSTRUCTIONS AND DEFINITIONS

- 1. For this survey, a **health insurance plan** is defined as providing **hospital and/or physician coverage** for a **single premium** to employees and/or retirees. Exclude extra-cash plans (a specified number of dollars per day in the hospital) or dread-disease (e.g., cancer-only) plans.
- 2. Coverage could have been purchased from an insurance company, provided by a union or trade association, or self-insured by your governmental unit.
- **3. Single and family** plans offered by the same insurance company and providing the same level of hospital and physician benefits count as **one plan**.
- 4. High and low options of a plan offered by the same insurance company count as two plans.
- 5. An HMO and a conventional plan offered by the same insurance company count as two plans.
- **6. Estimates** are acceptable if you do not have this information readily available.
- 7. Provide information for the **pay period that included July 1, 1996** for characteristics such as coverage, premiums, and enrollment. Annual totals, such as costs, should be for **calendar year 1996**, if possible, or for the plan year that included July 1, 1996.

	Section A - NUMBER OF PLANS
A1.	Did you make available or contribute to the cost of any health insurance plans for your employees or retirees on July 1, 1996? See instructions 1–5 above for a description of health insurance plans.
001	1 ☐ Yes OND NO - If No, go to Section C on page 3. How many?
	Continue with Section B on page 2.

PLEASE ENCLOSE A COPY OF EACH PLAN BROCHURE WITH YOUR DATA SUBMISSION

	Section B - PLAN	CHARA	CTERISTICS
B1.	On July 1, 1996, what was the name of the health insurance plan with the highest enrollment and its carrier? For additional plans that you offer, use the Supplemental Sheets (if any) or a copy of this page.	B3b.	Enter this plan's total premium, employer contribution, and employee contribution for an enrolled family (of four). Report for the same premium period as in Question B3a.
	FOR CENSUS USE ONLY		If self-insured, enter the monthly premium equivalent.
100		134 135	\$.00 Total premium
⁰¹² Nam	e of plan	136	\$.00 Employer contribution
¹⁰² Nam	e of insurance carrier	137	\$.00 Employee contribution □ Family coverage was not offered
124 b. 125	For this plan, enter the total number of enrollees excluding dependents for this governmental unit on July 1, 1996. Enter the total number of active employees enrolled. Enter the number of former employees enrolled through COBRA or other State continuation-of-benefits laws.	B4. 105	Indicate the type of indemnification of this plan. 1 Purchased from an insurance underwriter – Coverage is purchased from an insurance company or other underwriter who assumes the risk for enrollees' medical expenses. 2 Self-insured – Your governmental unit pays the claims from its resources and may charge a premium to employees. The plan may be administered by a third party. This type may employ supplemental stop-loss insurance to limit unanticipated losses.
		B5a.	Is this plan offered in 1997?
d.	Enter the number of retirees enrolled. 128 65 and older	186	1 ☐ Yes – If Yes, go to Question B5c. 2 ☐ No
e. 129	Enter the total number of enrollees with single coverage.	b.	If it is not still offered, indicate if it has been – 1 Replaced with a similar plan 2 Replaced by a substantially different plan 3 Dropped without
ВЗа.	Enter this plan's total premium, employer contribution, and employee contribution for a typical full-time employee with single coverage.		offering a replacement – Go to Section C on page 3.
	If self-insured, enter the monthly premium equivalent.	C.	premiums for this plan or the one that took its place.
130	\$.00 Total premium	188	Report for the same premium period as in Question B3a.
131	\$.00 Employer contribution		Single enrollment
132	\$.00 Employee contribution	189	Family enrollment
133	Indicate the premium period 1 Week 2 2 2 weeks 3 Month 4 Year	190	\$.00 Single premium \$.00 Family premium

Please complete one Supplemental Sheet for each additional hospital/physician plan you offered your employees and retirees on July 1, 1996. You may use photocopies of the Supplemental Sheet or Section B of this form, if necessary.

Control No.

		Secti	ion C – EMPLOYMI	ENT CH	ARACTERI	STICS	
C1.	Enter the total annual that included July 1, 1 plans offered by your employer and employ	996 for ALL hogovernmental i	spital/physician unit. <i>Include</i>	C3.	Enter the nu	period that included July	038
199	\$.00			b.	Enter the nu	ımber of employees I or older	039
C2.	governmental unit and leased or contract wo	on your payrol ude employees vith your goverr rance, also ente r coverage and d dependent ag	Il for each of the of any dependent of any dependent of the number of enrolled through your		Enter the nu (1) Less tha	mber of employees nion members	042 043 043
a.	All employees					· •	044
200	Total 201	Eligible	Enrolled 202		(3) More th	an \$15.00 per hour	
b.	Part-time employees			C4.	How many h	nours per week must an full time at your governn	employee work to be
203	Total 204	Eligible	Enrolled	041		ours	
C.	Temporary (seasonal)	employees		C5.		any of these fringe bene	 efits?
206	Total 207	Eligible	Enrolled		Check all tha		
206	207		208	050	_		
219	²¹⁰ ☐ Retirees 6	or other continu	uation-of-benefits 2 □ No	050 051 052 053 054 055 056	☐ Retireme ☐ Medical ☐ Flexible ☐ Cafeteria	k leave irance y insurance ent/pension plans Savings Accounts (MSA spending accounts a plan – e average value per	.00
500 Rem	arks						
		Section D	- PERSON COMPL			TIONNAIRE	
²¹² Nam	e (Please print)			²¹³ Title			
Signatur	re						¹ 214 Date
3							I
²¹⁵ Teler	phone number	²²⁰ Extension	²¹⁶ FAX number			²¹⁷ E-Mail address	I
()		()				
	PLEAS	SE ENCLOSE A	COPY OF EACH PLAN	BROCHU	RE WITH YOU	JR DATA SUBMISSION	

FORM **MEPS-11(CS)**

U.S. DEPARTMENT OF COMMERCE BUREAU OF THE CENSUS ACTING AS COLLECTING AGENT FOR U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

MEDICAL EXPENDITURE PANEL SURVEY (INSURANCE COMPONENT)

SUPPLEMENTAL SHEET GOVERNMENT/CERTAINTY QUESTIONNAIRE

(MEPS Suppl	 This Supplemental Sheet is a reprint of the questio S-11(C)). You may use it to report additional health plemental Sheet if sufficient copies were not included age of the Government/Certainty Questionnaire (MEF) 	an inform in vour re	nation. You may use photocopies of this eporting package. Refer to the instructions on the
	Section B – PLAN (CHARAC	TERISTICS
in	nter the name of the health insurance plan and the surance carrier. FOR CENSUS USE ONLY	134	Enter this plan's total premium, employer contribution, and employee contribution for an enrolled family (of four). Report for the same premium period as in Question B3a. If self-insured, enter the monthly premium equivalent. \$
O12 Name o	of plan of insurance carrier	135 [136 [137	\$.00 Employer contribution \$.00 Employee contribution □ Family coverage was not offered
124 [b. E 125 [For this plan, enter the total number of enrollees excluding dependents for this governmental unit on July 1, 1996. Enter the total number of active employees enrolled. Enter the number of former employees enrolled through COBRA or other State continuation-of-benefits laws.	105	Indicate the type of indemnification of this plan. Purchased from an insurance underwriter – Coverage is purchased from an insurance company or other underwriter who assumes the risk for enrollees' medical expenses. Self-insured – Your governmental unit pays the claims from its resources and may charge a premium to employees. The plan may be administered by a third party. This type may employ supplemental stop-loss insurance to limit unanticipated losses.
127	Enter the number of retirees enrolled. 128 Total 65 and older Enter the total number of enrollees with single coverage.	186 . 2 b. 1	Is this plan offered in 1997? 1 Yes - If Yes, go to Question B5c. 2 No If it is not still offered, indicate if it has been - 1 Replaced with a similar plan 2 Replaced by a substantially different plan
6	Enter this plan's total premium, employer contribution, and employee contribution for a typical full-time employee with single coverage. If self-insured, enter the monthly premium equivalent.	C. 	Dropped without offering a replacement – END THIS FORM. For 1997, enter the single and family enrollments and premiums for this plan or the one that took its place. Report for the same premium period as in Question B3a. Single enrollment
131	\$.00 Total premium \$.00 Employer contribution \$.00 Employee contribution	191	\$.00 Single premium \$.00 Family premium
	Indicate the premium period Week 2 2 2 weeks 3 Month 4 Year PLEASE ENCLOSE A COPY OF EACH PLAN I	pl	you have any questions concerning this survey, ease call 1–888–206–5068. RE WITH YOUR DATA SUBMISSION

FORM **MEPS-11** (7-7-97)

U.S. DEPARTMENT OF COMMERCE BUREAU OF THE CENSUS ACTING AS COLLECTING AGENT FOR U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

MEDICAL EXPENDITURE PANEL SURVEY (INSURANCE COMPONENT)

GOVERNMENT QUESTIONNAIRE

Collection of this information is authorized under Title IX, Section 902(a) of the Public Health Service Act. Sections 903(c) and 308(d) of that Act specify that all information will be held in strict confidence by the staff of the Agency for Health Care Policy and Research and their authorized contractors.

RETURN TO Bureau of the Census 1201 East 10th Street Jeffersonville, IN 47132-0001

If you have any questions concerning this survey, please call 1–888–273–3878.

Continue with Section B on page 2.

Please correct errors in name, address, and ZIP Code. ENTER number and street if not shown.

A FEW IMPORTANT INSTRUCTIONS AND DEFINITIONS

- 1. For this survey, a **health insurance plan** is defined as providing **hospital and/or physician coverage** for a **single premium** to employees and/or retirees. Exclude extra-cash plans (a specified number of dollars per day in the hospital) or dread-disease (e.g., cancer-only) plans.
- 2. Coverage could have been purchased from an insurance company, provided by a union or trade association, or self-insured by your governmental unit.
- **3. Single and family** plans offered by the same insurance company and providing the same level of hospital and physician benefits count as **one plan**.
- 4. High and low options of a plan offered by the same insurance company count as two plans.
- 5. An HMO and a conventional plan offered by the same insurance company count as two plans.
- 6. For the deductibles, copayments, and premiums, report for typical situations and enrollees. If cost varies by family size, use a family of four. If cost varies by age, provide the information for the average age of your workers.
- 7. Estimates are acceptable if you do not have this information readily available.
- 8. Provide information for the **pay period that included July 1, 1996** for characteristics such as coverage, premiums, and enrollment. Annual totals, such as costs, should be for **calendar year 1996**, if possible, or for the plan year that included July 1, 1996.

Section A - NUMBER OF PLANS

A1. Did you make available or retirees on July 1, 1996?	contribute to the cost of any health insurance plans for your employees of See instructions 1–5 above for a description of health insurance plans.
001 1 ☐ Yes / How many?	2 □ No − If No, go to Section D on page 5.

	Section B – PLAN (CHARAC	TERISTICS		
B1.	On July 1, 1996, what was the name of the health insurance plan with the highest enrollment and its carrier? For additional plans that you offer, use the Supplemental Sheets (if any) or a copy of Section B of this form.	B5c.	Enter this governmental un coverage for this plan for th July 1, 1996. Include: claims and stop-loss coverage (if a employee contributions.	ne plan yea s paid, adm	r that included ninistrative costs,
	FOR CENSUS USE ONLY	108			nly plan you
100			\$.00 off	ered, also e Question C	enter this amount 3 on page 4.
⁰¹² Nam	e of plan	d.	Enter the monthly premiu amount if premium equival single and family (of four) of employee. Include the costs	ents were recoverage for entered in	not calculated) for r a typical full-time n B5c. <i>Also enter</i>
¹⁰² Nam	e of insurance carrier	109	this information in Question (family) – Total premium or	n B10a (sin n page 3.	gle) and B10b
B2.	Indicate the type of providers in this plan.		\$.00 Sir	igle covera	ge
103	Exclusive providers – Enrollees must go to providers associated with the plan except in an emergency. There is typically no cost or a small fixed cost for each physician visit. (For example, HMOs, IPAs, EPOs)	e.	\$.00 Far		ge
	2 Any providers – Enrollees can go to the physicians of their choice on a fee-for-service basis. The plan does not have any associated providers. (For example, conventional plans, indemnity plans)		2 A COBRA amount?		
	3 Mixture of preferred and any providers – Enrollees can go to a set of "preferred" providers associated with the plan, or providers of their choice. If they go to a non-preferred provider, they face higher costs. (For example, PPOs, POSs)	113 114 Name	Was this plan operated by a $1 \square \text{ Union }_{\cancel{F}} = 2 \square \text{ Trade }_{\cancel{F}}$ of union or trade association	Associatior	a 3 □ Neither 115 Local number,
B3.	Did this plan require that the enrollee see a primary-care physician in order to be referred to a specialist?				if a union
104	1 ☐ Yes 2 ☐ No	116 Name	of insurance representative		
B4.	Indicate the type of indemnification of this plan.	117 Addre	ss (Number and street)		
105	Purchased from an insurance underwriter – Coverage is purchased from an insurance company or other underwriter who assumes the risk for enrollees' medical expenses.	118 City		¹¹⁹ State	¹²⁰ ZIP Code
	If purchased, go to Question B6.				
	_	121 Teleph	one number		
	2 Self-insured – Your governmental unit pays the claims from its resources and may charge a	()		
	premium to employees. The plan may be administered by a <i>third party</i> . This type may employ supplemental <i>stop-loss insurance</i> to limit unanticipated losses.	B7.	Did any enrollee receive a contribution towards any parties of a union)?		
	For self-insured plans only:	122	1 ☐ Yes 2 ☐ No		
B5a.	Indicate if you administered the plan or if you employed a third party.	B8.	In what month did the plan	year begin	?
106	1 ☐ Self-administered 2 ☐ Insurance company or other administrator		Enter a numeric response (e.g., Jan = 01, May = 05).	123	Month
b.	Did you purchase stop-loss coverage?				
107	1 ☐ Yes 2 ☐ No				

Page 2 FORM MEPS-11 (7-7-97)

	Section B – PLAN CHARA	CTERIST	TICS – Continued
B9a.	For this plan, enter the total number of enrollees excluding dependents for this governmental unit on July 1, 1996.	B11b.	Did the amount of the employee contribution (not premium) vary for different employee categories (e.g., full-time, part-time, retiree)?
124		143	1 ☐ Yes 2 ☐ No
b.	Enter the total number of active employees enrolled.	B12.	Did this plan's premium include either of these services? Check all that apply.
		144 — — — —	Life insurance 145 Disability insurance
C.	Enter the number of former employees enrolled through COBRA or other State continuation-of-benefits laws.	B13.	Enter the annual deductibles that enrollees paid out of their pockets before the plan began paying for covered services (using the plan's providers). Many HMO-type plans do not have deductibles.
d.	Enter the number of retirees enrolled.	146	\$.00 Total individual annual deductible OR $ abla$
127	128 65 and		Separate deductibles for:
e.	Enter the total number of enrollees with single coverage.		\$.00 Physician care
129			\$.00 Hospital care
B10a.	Enter this plan's total premium, employer contribution, and employee contribution for a typical full-time	149	If the deductible is per overnight hospital stay, report under B14a.
	employee with single coverage.		\$.00 Total family annual deductible (if applicable)
130	If self-insured, enter the monthly premium equivalent from Question B5d on page 2.	150	Number of persons – Enter if the plan also specified that the family deductible was met when a number of family members fulfilled
	\$.00 Total premium		their individual deductibles.
131	\$.00 Employer contribution	151 — — — —	Plan did not have a deductible
132	\$.00 Employer contribution \$.00 Employee contribution	B14a.	How much did an enrollee pay for an overnight hospital stay (in a participating hospital, if applicable) after any annual deductible was met?
	Indicate the premium period 🔀	152	\$.00
133	1 Week 2 2 weeks 3 Month 4 Year		S .00 2 Per stay
b.	Enter this plan's total premium, employer contribution, and employee contribution for an enrolled family (of four).	153	Percent OR
	Report for the same premium period as in B10a.	155	☐ Hospital care was not covered
134	If self-insured, enter the monthly premium equivalent from Question B5d on page 2.	b.	How much did an enrollee pay for an office visit (with a participating physician, if applicable) after any annual deductible was met?
	\$.00 Total premium	156	\$.00
135	\$.00 Employer contribution		OR
136	\$.00 Employee contribution	157	Percent OR
137	Family coverage was not offered	218	Physician care was not covered
B11a.	Did the premiums (not contributions) vary by –	B15.	What was the maximum amount this plan would have paid for an individual –
138	Check all that apply.	a.	Over the enrollee's lifetime?
139	☐ Age? ☐ Sex?	159	\$.00
140	Number of persons (within family coverage)?	b.	In one year?
141 142	Wage or salary levels?☐ Other? – Specify	160	in one year:
099	Callett Optiony		\$.00
		158	☐ No maximum

	Section B – PLAN CHARA	CTERIST	ΓICS – Continued
B16.	What was the maximum annual out-of-pocket amount for –	B18.	Could this plan have refused to cover persons with certain preexisting conditions?
	An individual?	183	1 ☐ Yes ⊋ 2 ☐ No
161	\$.00	184	Did this happen in 1996?
	A family (of four)?		1 Yes 2 No
162	\$.00	B19.	Could this plan have imposed a waiting period for persons with certain preexisting conditions?
163	☐ No maximum	185 — — — —	1 ☐ Yes 2 ☐ No
B17.	Indicate which of these services were included in the plan.	B20a.	Is this plan offered in 1997?
	Check all that apply.	186	1 ☐ Yes - If Yes, go to Question B20c. 2 ☐ No
164 165	Routine mammograms	b.	If it is not still offered, indicate if it has been -
166	☐ Adult routine physical exams ☐ Routine pap smears	187	1 Replaced with a similar plan
167	Office visits for prenatal care		2 Replaced by a substantially different plan 3 Dropped without offering a replacement – Go to Section C.
168 169	Adult immunizations		
170	☐ Child immunizations	J 0.	For 1997, enter the single and family enrollments and premiums for this plan or the one that took its place.
170	Well-baby care, under 1 yearWell-child care, 1−4 years		Report for the same premium period as in Question B10a on page 3.
172	☐ 100% well-baby care	188	c., page c.
173	Chiropractic care		Single enrollment
174 175	☐ Other non-physician providers ☐ Outpatient prescriptions	189	Family enrollment
176	Routine dental care	190	
177	Orthodontic care		\$.00 Single premium
178	☐ Nursing home care	191	\$.00 Family premium
179	☐ Home health care		
180	Inpatient mental illness	additi	e complete one Supplemental Sheet for each ional hospital/physician plan you offered your
181 182	☐ Outpatient mental illness ☐ Alcohol/substance abuse treatment	photo	byees and retirees on July 1, 1996. You may use becopies of the Supplemental Sheet or Section B of
			orm, if necessary.
_	Section C – GENERAL HEALTH		GE CHARACTERISTICS
C1a.	Did you offer optional coverage (not included in the basic health coverage) for any of these services in 1996 at an additional premium to the employee?	C2a.	Did you impose a waiting period before new employees could be covered by health insurance?
	Check all that apply.	197	1 ☐ Yes $ ot ot $ 2 ☐ No
192	☐ Dental	b.	What was the typical waiting period?
193 194	Vision	198	1 Less than 2 weeks
195	☐ Prescription drugs ☐ Long-term care		2
	•		4 ☐ More than 3 months
b.	What was the total amount paid for these coverages in 1996? <i>Include employer and employee contributions</i> .	C3.	
196	\$.00		that included July 1, 1996 for ALL hospital/physician plans offered by your governmental unit. <i>Include employer and employee contributions</i> .
		199	
			\$.00

Page 4 FORM MEPS-11 (7-7-97)

		Secti	on D – EN	IPLOYME	ENT CH	ARACTERIS	STICS		
D1.	For the pay period inc number of employees categories below. Incl agencies associated w	on your payro ude employees	II for each o of any dep	f the endent		who were un	mber of employed		040
	offered health insur employees eligible an governmental unit and leased or contract woo	rance, also ente d enrolled for o d dependent ag	er the numb coverage thr	er of ough your	a.		mber of employe n \$6.50 per hour		042
		Eligible	Enro	lled		(2) Between	n \$6.50 and \$15.0	00 per hour	043
200	201		202			(3) More tha	an \$15.00 per ho — — — — —	our - — — — —	
		Eligible	Enro	lled	D3.	How many h considered for	ours per week m ull time at your (nust an emplo governmenta	oyee work to be I unit?
203	204		205		041	Hou	urs		
C.	Temporary (seasonal) Total	employees Eligible	Enro	lled	D4.	Do you offer	any of these frin	ge benefits?	
206	207	g	208		050	Check all that			
d.	Were retirees eligible than through COBRA laws) on July 1, 1996?	or other continu	th insurance uation-of-be	e (other nefits	050 051 052 053	☐ Paid vaca☐ Paid sick☐ Life insu	leave rance		
219	1 ☐ Yes – Check all th		2 🗆 No		054 055		ent/pension plans		
		under 65 years 65 years and ov	/er		056	☐ Flexible s	Savings Accoung spending accourt		
D2.	For the pay period tha	t included July	1, 1996 – 038		=	☐ Cafeteria Enter the annual v	e average oso		
a.	Enter the number of wemployees					employe	ee	\$.00
b.	Enter the number of e 50 years old or older	mployees 	039						
500 Rema	arks								
		Section E -	- PERSON	COMPL	,	THIS QUEST	TIONNAIRE		
²¹² Name	e (Please print)				²¹³ Title				
Signatur	е				1			214 [Date
215 7-1-	hana numban	220 -	216 FAV				217 🗆 🐧 - : 1 1 - 1		
1 elep	phone number)	²²⁰ Extension	²¹⁶ FAX nui))			²¹⁷ E-Mail addr	ess	

	OMB No. 0935-0098: Approval Expires 04/30/98
FORM MEPS-11(P) (7-7-97)	
U.S. DEPARTMENT OF COMMERCE	
BUREAU OF THE CENSUS ACTING AS COLLECTING AGENT FOR	
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES	
MEDICAL EXPENDITURE PANEL SURVEY	
(INSURANCE COMPONENT)	
·	
PERSON-LEVEL QUESTIONNAIRE FOR GOVERNMENTAL UNITS	
Collection of this information is authorized under Title IX, Section 902(a) of the Public Health Service Act. Sections 903(c) and 308(d) of that Act specify that all information will be held in strict confidence by the staff of the Agency for Health Care Policy and Research and their authorized contractors.	
RETURN TO	
If you have any questions concerning this survey,	
please call	
A FEW IMP	ORTANT INSTRUCTIONS AND DEFINITIONS
by the individual authorizing our collection package.	to the individual named in the label area. A permission slip signed n of this information is included at the back of the reporting
for a single premium to employees and	is defined as providing hospital and/or physician coverage for retirees. Also included in Section C of this questionnaire are hal coverage not included in the basic health insurance plan(s) for
Section A – F	PERSON-LEVEL INFORMATION
A1. Which category below best describes this person	's status with your governmental unit on July 1, 1996?
	s status with your governmental unit on July 1, 1990:
Check only ONE.	
⁰⁶⁵ 1 A full- or part-time employee	
2 A retiree	
3 A former employee	Go to Section B on page 2.
4 \(\sum \) A relative/survivor of a former employee 5 \(\sum \) A seasonal or temporary employee	
3 El A scasonal of temporary employee	
6 ☐ An employee of a temporary agency]	
· · · · · · · · · · · · · · · · · · ·	to Section D on page 3.
8 No record of this person	

	Section B – HOSPITAL	ONFI	I SICIAIN PLAIN
B1a.	Was this person eligible for hospital/physician insurance coverage through your governmental unit on July 1, 1996?	B4.	For the pay period including July 1, 1996, provide the information below regarding premiums paid for this person's hospital/physician coverage.
350	1 ☐ Yes 2 ☐ No - If No, go to Section C on page 3.	a.	What was the total premium including both employer and employee contributions?
	If more than one plan was offered through this governmental unit, answer Part b below. If only one plan was offered, go to Question B2a.		If this plan was self-insured, enter the monthly premium equivalent. If a premium equivalent was not calculated, enter the COBRA amount.
b.	Of the hospital/physician plans offered by your governmental unit, for which plans was this person	361	\$.00 PER → 2 □ 2 weeks
	eligible? Please enter plan name(s) exactly as entered in Question B1 of the Governmental Questionnaire		3 ☐ Month 4 ☐ Year
351	(MEPS-11) or Supplemental Sheet (MEPS-11(S)). ☐ All OR ✓	b.	How much did this person contribute towards his/her coverage?
501 502		362	Report for the same premium period as in Question B4a.
503			\$.00 OR
504		353	Percent of insurance premium
B2a.	Was this person enrolled in a hospital/physician plan provided by your governmental unit on July 1, 1996?	C.	How much did your governmental unit contribute towards this person's coverage?
231	1 ☐ Yes 2 ☐ No – If No, go to Section C on page 3.	363	Report for the same premium period as in Question B4a.
	If more than one plan was offered through this governmental unit, answer Part b below. If only		\$.00 OR
	one plan was offered, go to Question B3.		
b.	one plan was offered, go to Question B3.	354	Percent of insurance premium
b.	In which hospital/physician plan(s) was this person enrolled? Please enter plan name(s) exactly as entered in Question B1 of the Governmental Questionnaire		Percent of insurance premium How much did sources other than your governmental unit, such as a union, contribute towards/subsidize this person's coverage?
b.	In which hospital/physician plan(s) was this person enrolled? Please enter plan name(s) exactly as entered in Question B1 of the Governmental Questionnaire (MEPS-11) or Supplemental Sheet (MEPS-11(S)).	d.	Percent of insurance premium How much did sources other than your governmental unit, such as a union, contribute towards/subsidize this person's
	In which hospital/physician plan(s) was this person enrolled? Please enter plan name(s) exactly as entered in Question B1 of the Governmental Questionnaire		Percent of insurance premium How much did sources other than your governmental unit, such as a union, contribute towards/subsidize this person's coverage?
352	In which hospital/physician plan(s) was this person enrolled? Please enter plan name(s) exactly as entered in Question B1 of the Governmental Questionnaire (MEPS-11) or Supplemental Sheet (MEPS-11(S)).	d.	Percent of insurance premium How much did sources other than your governmental unit, such as a union, contribute towards/subsidize this person's coverage? Report for the same premium period as in Question B4a. \$.00
352 021 505	In which hospital/physician plan(s) was this person enrolled? Please enter plan name(s) exactly as entered in Question B1 of the Governmental Questionnaire (MEPS-11) or Supplemental Sheet (MEPS-11(S)).	d.	Percent of insurance premium How much did sources other than your governmental unit, such as a union, contribute towards/subsidize this person's coverage? Report for the same premium period as in Question B4a. \$.00 OR Percent of insurance premium OR
352 021 505	In which hospital/physician plan(s) was this person enrolled? Please enter plan name(s) exactly as entered in Question B1 of the Governmental Questionnaire (MEPS-11) or Supplemental Sheet (MEPS-11(S)).	d. 355	Percent of insurance premium How much did sources other than your governmental unit, such as a union, contribute towards/subsidize this person's coverage? Report for the same premium period as in Question B4a. \$.00 OR Percent of insurance premium
352 021 505	In which hospital/physician plan(s) was this person enrolled? Please enter plan name(s) exactly as entered in Question B1 of the Governmental Questionnaire (MEPS-11) or Supplemental Sheet (MEPS-11(S)).	d. 355 356	Percent of insurance premium How much did sources other than your governmental unit, such as a union, contribute towards/subsidize this person's coverage? Report for the same premium period as in Question B4a. \$.00 OR Percent of insurance premium OR No subsidy/contribution from other sources – Go to Question B6.
352 021 505	In which hospital/physician plan(s) was this person enrolled? Please enter plan name(s) exactly as entered in Question B1 of the Governmental Questionnaire (MEPS-11) or Supplemental Sheet (MEPS-11(S)). □ All OR ✓	d. 355	Percent of insurance premium How much did sources other than your governmental unit, such as a union, contribute towards/subsidize this person's coverage? Report for the same premium period as in Question B4a. \$.00 OR Percent of insurance premium OR No subsidy/contribution from other sources – Go to Question B6. What was the source of the outside subsidy or contribution reported in B4d?
352 021 505	In which hospital/physician plan(s) was this person enrolled? Please enter plan name(s) exactly as entered in Question B1 of the Governmental Questionnaire (MEPS-11) or Supplemental Sheet (MEPS-11(S)). □ All OR ✓	d. 355 356	Percent of insurance premium How much did sources other than your governmental unit, such as a union, contribute towards/subsidize this person's coverage? Report for the same premium period as in Question B4a. \$.00 OR Percent of insurance premium OR No subsidy/contribution from other sources – Go to Question B6. What was the source of the outside subsidy or contribution reported in B4d? Check only ONE.
352 021 505	In which hospital/physician plan(s) was this person enrolled? Please enter plan name(s) exactly as entered in Question B1 of the Governmental Questionnaire (MEPS-11) or Supplemental Sheet (MEPS-11(S)). □ All OR ✓	d. 355 356 357 B5 .	Percent of insurance premium How much did sources other than your governmental unit, such as a union, contribute towards/subsidize this person's coverage? Report for the same premium period as in Question B4a. \$.00 OR Percent of insurance premium OR No subsidy/contribution from other sources – Go to Question B6. What was the source of the outside subsidy or contribution reported in B4d?
352 021 505	In which hospital/physician plan(s) was this person enrolled? Please enter plan name(s) exactly as entered in Question B1 of the Governmental Questionnaire (MEPS-11) or Supplemental Sheet (MEPS-11(S)). □ All OR ✓	d. 355 356 357 B5 .	Percent of insurance premium How much did sources other than your governmental unit, such as a union, contribute towards/subsidize this person's coverage? Report for the same premium period as in Question B4a. \$.00 OR Percent of insurance premium OR No subsidy/contribution from other sources – Go to Question B6. What was the source of the outside subsidy or contribution reported in B4d? Check only ONE. 1 Union

Page 2 FORM MEPS-11(P) (7-7-97)

Control No.

	Section C - SINGL	E-SER\	/ICE PLANS
C1.	On July 1, 1996, did this person obtain through your governmental unit any optional coverage (not included in his/her basic health plan reported in Section B above) at an additional premium?	C3a.	What was the total premium for all single-service plans obtained by this person, including employer and employee contributions?
246	1 Yes 2 No – If No, go to Section D.	374	\$.00 PER -> 2 \(\times 2 \) Week 380 1 \(\times \) Week 2 \(\times 2 \) 2 weeks 3 \(\times \) Month
C2.	Which of the following single-service plans did this person obtain?		4 ☐ Year
	Check all that apply.	b.	How much did this person contribute towards his/her single-service plan coverage?
370 372	☐ Dental ☐ Vision	375	Report for the same premium period as in Question C3a.
371 373	☐ Prescription drugs ☐ Long-term care	3/3	\$.00
		360	OR Percent of insurance premium
500 Ren	narks		
	Section D – PERSON COMPL	ETING	THIS QUESTIONNAIRE
²¹² Nan	ne (Please print)	²¹³ Title	
C: 1			214 15.1.
Signatu	ire		²¹⁴ Date
²¹⁵ Tele	phone number 220 Extension 216 FAX number		²¹⁷ E-Mail address
I () ()		

FORM MEPS-11(P) (7-7-97) Page 3

FORM **MEPS-11(S)**

U.S. DEPARTMENT OF COMMERCE BUREAU OF THE CENSUS ACTING AS COLLECTING AGENT FOR U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

MEDICAL EXPENDITURE PANEL SURVEY (INSURANCE COMPONENT)

SUPPLEMENTAL SHEET GOVERNMENT QUESTIONNAIRE

INSTRUCTIONS

This Supplemental Sheet is a reprint of the questions in Section B of the Government Questionnaire (MEPS-11). You

may use it to report additional health plan information. You may use photocopies of this Supplemental Sheet if sufficient copies were not included in your reporting package. Refer to the instructions on the first page of the Government Questionnaire (MEPS-11) when completing this Supplemental Sheet.							
	Section B – PLAN CHARACTERISTICS						
B1.	Enter the name of the health insurance plan and the insurance carrier.		For self-insured plans only:				
	FOR CENSUS USE ONLY	B5a.	Indicate if you administered the plan or if you employed a third party.				
100		106	1 ☐ Self-administered 2 ☐ Insurance company or other administrator				
⁰¹² Nam	e of plan	b.	Did you purchase stop-loss coverage?				
¹⁰² Nam	e of insurance carrier	107	1 ☐ Yes 2 ☐ No				
B2.	Lathara de la caractería de la della de la	c.	Enter this governmental unit's total annual cost of coverage for this plan for the plan year that included July 1, 1996. Include: claims paid, administrative costs,				
103 B3.	Indicate the type of providers in this plan. 1 Exclusive providers – Enrollees must go to providers associated with the plan except in an emergency. There is typically no cost or a small fixed cost for each physician visit. (For example, HMOs, IPAs, EPOs) 2 Any providers – Enrollees can go to the physicians of their choice on a fee-for-service basis. The plan does not have any associated providers. (For example, conventional plans, indemnity plans) 3 Mixture of preferred and any providers – Enrollees can go to a set of "preferred" providers associated with the plan, or providers of their choice. If they go to a non-preferred provider, they face higher costs. (For example, PPOs, POSs) Did this plan require that the enrollee see a primary-care physician in order to be referred to a specialist?	108 d. 109	and stop-loss coverage (if any). Include employer and employee contributions. \$.00 Enter the monthly premium equivalents (or the COBRA amount if premium equivalents were not calculated) for single and family (of four) coverage for a typical full-time employee. Include the costs entered in B5c. Also enter this information in Question B10a (single) and B10b (family) – Total premium on page 2. \$.00 Single coverage				
104	1 □ Yes 2 □ No 	e.	Is the amount entered in B5d –				
B4.	Indicate the type of indemnification of this plan. 1 Purchased from an insurance underwriter – Coverage is purchased from an insurance company or other underwriter who assumes the risk for enrollees' medical expenses. If purchased, go to Question B6 on page 2. 2 Self-insured – Your governmental unit pays the claims from its resources and may charge a premium to employees. The plan may be administered by a third party. This type may employ supplemental stop-loss insurance to limit unanticipated losses.	111	1 ☐ A premium equivalent? 2 ☐ A COBRA amount?				

	•	Section B -	- PLAN CHARA	CTERIST	TICS – Continued	
B6.	Was this plan operated by a 1 ☐ Union ⊋ 2 ☐ Trade		_Z з □ Neither	B10a.	and employee contribut employee with single c	
¹¹⁴ Name	of union or trade association	11	¹⁵ Local number, if a union	130	from Question B5d on p	monthly premium equivalent page 1. Total premium
¹¹⁶ Name	of insurance representative			131		Employer contribution
117 Addres	ss (Number and street)			132	\$.00	Employee contribution eriod
¹¹⁸ City		¹¹⁹ State	¹²⁰ ZIP Code	133	1 ☐ Week 2 ☐ 2 w	veeks 3 Month 4 Year
121 Teleph	one number			b.	Enter this plan's total p and employee contribut (of four).	remium, employer contribution ion for an enrolled family
B7 .	Did any enrollee receive a contribution towards any pa (e.g., from a union)?					mium period as in Question B10a. monthly premium equivalent page 1.
122	1 ☐ Yes 2 ☐ No			134 135	\$.00	Total premium
B8.	In what month did the plan Enter a numeric response (e.g., Jan = 01, May = 05).	year begin?	Month	136		Employer contribution Employee contribution
B9a.	For this plan, enter the total dependents for this government	number of e nental unit or	— — — — — — - nrollees excluding n July 1, 1996.	137	Family coverage wa	s not offered
124					Did the premiums (not Check all that apply.	contributions) vary by –
b.	Enter the total number of ac	ctive employe	ees enrolled.	138 139 140 141 142	☐ Age? ☐ Sex? ☐ Number of persons ☐ Wage or salary leve ☐ Other? – Specify	s (within family coverage)? els?
	Enter the number of former COBRA or other State conti	employees e nuation-of-be	enrolled through enefits laws.	099		
126				b.	Did the amount of the (not premium) vary for (e.g., full-time, part-time	employee contribution different employee categories e, retiree)?
d.		s enrolled.	65 and	143	1 □ Yes	2 □ No
	Enter the total number of e	nrollees with	older single coverage.	B12.	Check all that apply.	n include either of these services?
129				144	☐ Life insurance 14	⁵ □ Disability insurance

Page 2 FORM MEPS-11(S) (7-7-97)

	Section B - PLAN CHARACTERISTICS - Continued						
B13.	out of their pockets befo	tibles that enrollees paid re the plan began paying for the plan's providers). Many have deductibles.	B16.	What was the maximum annual out-of-pocket amount for – An individual?			
146		Total individual annual deductible OR ⊋	161	\$.00			
	Separate deductible	es for:					
	\$.00 Physician care	162	A family (of four)?			
	148 \$.00 Hospital care		\$.00			
		per overnight hospital stay,	163	□ No maximum - — — — — — — — — — — — — — — — — — — —			
149	\$.00	Total family annual deductible (if applicable) ☑	B17.	Indicate which of these services were included in the plan. Check all that apply.			
150	Number of pers	sons – Enter if the plan also he family deductible was met	164	☐ Routine mammograms			
		r of family members fulfilled	165 166	Adult routine physical exams			
151	☐ Plan did not have a de		167	☐ Routine pap smears			
 R14a	How much did an enroll		168	☐ Office visits for prenatal care			
D 1 4 u .	hospital stay (in a parti after any annual deducti	cipating hospital, if applicable)	169	☐ Adult immunizations ☐ Child immunizations			
152	a	154 1 Per day	170 171	Well-baby care, under 1 year			
	\$.00	2 ☐ Per stay	172	Well-child care, 1–4 years□ 100% well-baby care			
153			173	☐ Chiropractic care			
	Percent		174 175	☐ Other non-physician providers ☐ Outpatient prescriptions			
155	OR ☐ Hospital care was no	ot covered	176	☐ Routine dental care			
b.	,		177	Orthodontic care			
D.	a participating physician deductible was met?	ee pay for an office visit (with , if applicable) after any annual	178 179	☐ Nursing home care☐ Home health care			
156	\$.00		180	☐ Inpatient mental illness			
	OR		181 182	Outpatient mental illness			
157				Alcohol/substance abuse treatment			
	Percent OR		B18.	Could this plan have refused to cover persons with certain preexisting conditions?			
218	Physician care was n	ot covered	183	1 ☐ Yes 📈 2 ☐ No			
B15.	What was the maximum paid for an individual –	amount this plan would have	184	Did this happen in 1996?			
a.	Over the enrollee's life	etime?		1 □ Yes 2 □ No 			
159	\$.00		B19.	Could this plan have imposed a waiting period for persons with certain preexisting conditions?			
b.	In one year?		185	1 ☐ Yes 2 ☐ No			
160							
150	\$.00						
158	☐ No maximum						

Section B – PLAN CHARA	ACTERIST	ICS – Continued	
B20a. Is this plan offered in 1997?	B20c.	For 1997, enter the sing	le and family enrollments and or the one that took its place.
186 1 ☐ Yes – If Yes, go to Question B20c. 2 ☐ No			emium period as in Question B10a
The server of th	188	Cina	le enrollment
b. If it is not still offered, indicate if it has been – 187 1 ☐ Replaced with a similar plan	189		
2 Replaced by a substantially different plan	190	Fami	ly enrollment
3 Dropped without offering a replacement – END THIS FORM.		\$.00	Single premium
	191	\$.00	Family premium
⁵⁰⁰ Remarks			

FORM **MEPS-12** (7-7-97)

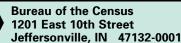
U.S. DEPARTMENT OF COMMERCE BUREAU OF THE CENSUS ACTING AS COLLECTING AGENT FOR U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

MEDICAL EXPENDITURE PANEL SURVEY (INSURANCE COMPONENT)

UNION QUESTIONNAIRE

Collection of this information is authorized under Title IX, Section 902(a) of the Public Health Service Act. Sections 903(c) and 308(d) of that Act specify that all information will be held in strict confidence by the staff of the Agency for Health Care Policy and Research and their authorized contractors.

RETURN TO



If you have any questions concerning this survey, please call 1–888–273–3878.

Please correct errors in name, address, and ZIP Code. ENTER number and street if not shown.

A FEW IMPORTANT INSTRUCTIONS AND DEFINITIONS

- 1. For this survey, a **health insurance plan** is defined as providing **hospital and/or physician coverage** for a **single premium** to members and/or retirees. Exclude extra-cash plans (a specified number of dollars per day in the hospital) or dread-disease (e.g., cancer-only) plans.
- 2. Coverage could have been purchased from an insurance company or self-insured by your union.
- **3. Single and family** plans offered by the same insurance company and providing the same level of hospital and physician benefits count as **one plan**.
- 4. High and low options of a plan offered by the same insurance company count as two plans.
- 5. An HMO and a conventional plan offered by the same insurance company count as two plans.
- **6.** If your union operates at more than one location, provide information for the location on the label unless otherwise directed.
- 7. For the deductibles, copayments, and premiums, report for typical situations and enrollees. If cost varies by family size, use a family of four. If cost varies by age, provide the information for the average age of your members.
- 8. Estimates are acceptable if you do not have this information readily available.
- **9.** Provide information for the **pay period that included July 1, 1996** for characteristics such as coverage, premiums, and enrollment. Annual totals, such as costs, should be for **calendar year 1996**, if possible, or for the plan year that included July 1, 1996.

	Section A – NUMBER OF PLANS				
A 1.	Did one or more of the individuals named in the label area of the accompanying Person-Level Questionnaire(s) (MEPS-12(P)) receive health insurance coverage through your union on July 1, 1996? See instructions 1–5 above for a description of health insurance plans?				
001	1 Yes 2 No - If No, go to Section D on page 5.				
A2.	How many different health insurance plans did you offer your members or retirees on July 1, 1996?				
003	Number of plans. See instructions 1–5 above for a description of health insurance plans – Continue with Section B on page 2.				

	Section B – PLAN (CHARA	CTERISTICS
B1.	On July 1, 1996, what was the name of the health insurance plan with the highest enrollment and its carrier?		Did you purchase stop-loss coverage?
	If you have received Supplemental Sheets (Form MEPS-12(S)) with plan names preprinted in Question B1, answer only for the preprinted plans. Otherwise, provide data for your 4 largest plans. You may make a copy of the Supplemental Sheet, or Section B of this form, if necessary.	107 C.	1 ☐ Yes 2 ☐ No Enter this union's total annual cost of coverage for this plan for the plan year that included July 1, 1996. Include: claims paid, administrative costs, and stop-loss coverage (if any). Include union and member contributions.
	FOR CENSUS USE ONLY	108	\$.00 If this is the only plan you offered also enter this amount
⁰¹² Nam	e of plan	d.	Enter the monthly premium equivalents for single and family (of four) coverage for a typical member. Include the costs entered in B5c. Also enter this information in Question B9a (single) and B9b (family) – Total premium on page 3.
¹⁰² Nam	e of insurance carrier	109	\$.00 Single coverage
B2.	Indicate the type of providers in this plan. 1 Exclusive providers – Enrollees must go to	110	\$.00 Family coverage
	providers associated with the plan except in an emergency. There is typically no cost or a small fixed cost for each physician visit. (For example, HMOs, IPAs, EPOs) 2 Any providers – Enrollees can go to the physicians of their choice on a fee-for-service basis. The plan	B6.	Did any enrollee receive a direct subsidy or contribution towards any part of the premium (e.g., from a government or employer)? 1 Yes 2 No
	does not have any associated providers. (For example, conventional plans, indemnity plans) 3 Mixture of preferred and any providers – Enrollees can go to a set of "preferred" providers associated with the plan, or providers of their choice. If they go to a non-preferred provider, they face higher costs. (For example, PPOs, POSs)	B7. B8a.	In what month did the plan year begin? Enter a numeric response (e.g., Jan = 01, May = 05). For this plan, enter the total number of enrollees excluding dependents for this union on July 1, 1996.
B3.	Did this plan require that the enrollee see a primary-care physician in order to be referred to a specialist? 1 Yes 2 No	124	
B4.	Indicate the type of indemnification of this plan. 1 Purchased from an insurance underwriter – Coverage is purchased from an insurance company or other underwriter who assumes the risk for enrollees' medical expenses.	125	Enter the total number of active members enrolled. Enter the number of retirees enrolled.
	If purchased, go to Question B6. 2 Self-insured – Your union pays the claims from its resources and may charge a premium to members. The plan may be administered by a <i>third party</i> . This type may employ supplemental <i>stop-loss insurance</i> to limit unanticipated losses.	127	Total 65 and older Enter the total number of enrollees with single coverage.
B5a.	For self-insured plans only: Indicate if you administered the plan or if you employed a third party. 1 Self-administered 2 Insurance company or other administrator	120	

Page 2 FORM MEPS-12 (7-7-97)

Section B - PLAN CHARACTERISTICS - Continued B9a. B12. Enter this plan's total premium, union contribution, and Enter the annual deductibles that enrollees paid member contribution for an enrollee with single out of their pockets before the plan began paving for covered services (using the plan's providers). Many coverage. HMO-type plans do not have deductibles. If self-insured, enter the monthly premium equivalent 146 **Total individual** from Question B5d on page 2. \$ annual deductible OR 🗸 130 Separate deductibles for: \$.00 Total premium 147 131 Physician care \$.00 Union contribution 148 Hospital care 132 .00 Member contribution If the deductible is per overnight hospital stay, report under B13a. Indicate the premium period 📈 149 **Total family annual** 133 1 Week 2 2 weeks з III Month 4 Year \$ 150 Number of persons – Enter if the plan also **b.** Enter this plan's **total** premium, union contribution, and specified that the family deductible was met member contribution for an enrolled family (of four). when a number of family members fulfilled their individual deductibles. Report for the same premium period as in Question B9a. Plan did not have a deductible If self-insured, enter the monthly premium equivalent from Question B5d on page 2. B13a. How much did an enrollee pay for an overnight hospital stay (in a participating hospital, if applicable) 134 after any annual deductible was met? \$.00 Total premium 152 1 Per day \$.00 135 2 Per stav \$.00 Union contribution OR 153 136 Percent \$.00 Member contribution OR 137 ☐ Family coverage was not offered Hospital care was not covered **B10a.** Did the **premiums** (not contributions) vary by – How much did an enrollee pay for an office visit (with a participating physician, if applicable) after any annual Check all that apply. deductible was met? 156 138 ☐ Age? \$.00 139 ☐ Sex? 140 ☐ Number of persons (within family coverage)? OR 142 Other? - Specify 157 099 Percent OR 218 Physician care was not covered **b.** Did the amount of the member contribution (not premium) vary for different member categories (e.g., full-time, part-time, seniority, work site, occupation)? B14. What was the maximum amount this plan would have paid for an individual -¹⁴³ 1 ☐ Yes 2 No a. Over the enrollee's lifetime? 159 B11. Did this plan's premium include either of these services? \$.00 Check all that apply. b. In one year? 160 144 145 ☐ Life insurance ☐ Disability insurance .00 158 ■ No maximum

	Section B - PLAN CHARACTERISTICS - Continued							
B15.	What was the maximum annual out-of-pocket amount for –	B17.	Could this plan have refused to cover persons with certain preexisting conditions?					
	An individual?	183	1 ☐ Yes 2 ☐ No					
161	\$.00	184	Did this happen in 1996?					
	A family (of four)?		1 Yes 2 No					
162	\$.00	B18.	Could this plan have imposed a waiting period for persons with certain preexisting conditions?					
163	☐ No maximum	185	1 ☐ Yes 2 ☐ No					
B16.	Indicate which of these services were included in the plan.	B19a.	Is this plan offered in 1997?					
	Check all that apply.	186	1 ☐ Yes – If Yes, go to Question B19c. 2 ☐ No					
164 165	☐ Routine mammograms ☐ Adult routine physical exams	b.	If it is not still offered, indicate if it has been –					
166	Routine pap smears	187	1 ☐ Replaced with a similar plan					
167	Office visits for prenatal care		2 Replaced by a substantially different plan 3 Dropped without					
168 169	☐ Adult immunizations ☐ Child immunizations		offering a replacement – Go to Section C.					
170	☐ Well-baby care, under 1 year	C.	For 1997, enter the single and family enrollments and premiums for this plan or the one that took its place.					
171 172	☐ Well-child care, 1–4 years		Report for the same premium period as in Question B9a on page 3.					
173	☐ 100% well-baby care ☐ Chiropractic care	188						
174 175	Other non-physician providers	189	Single enrollment					
175	Outpatient prescriptions		Family enrollment					
177	☐ Routine dental care ☐ Orthodontic care	190	\$.00 Single premium					
178	Nursing home care	191						
179	☐ Home health care		\$.00 Family premium					
180 181	☐ Inpatient mental illness☐ Outpatient mental illness☐	hospital/	omplete one Supplemental Sheet for each additional physician plan you offered your members and					
182	Alcohol/substance abuse treatment	Supplem	on July 1, 1996. You may use photocopies of the ental Sheet or Section B of this form, if necessary.					
	Section C – GENERAL HEALTH	COVERA	GE CHARACTERISTICS					
C1a.	Did you offer optional coverage (not included in the basic health coverage) for any of these services in 1996 at an additional premium to the member?	C2a.	Did you impose a waiting period before new members could be covered by health insurance?					
	Check all that apply.	197	1 ☐ Yes 2 ☐ No - If No, go to Question C3.					
192	☐ Dental	b.	What was the typical waiting period?					
193 194	☐ Vision ☐ Prescription drugs	198	1 Less than 2 weeks					
195	Long-term care		2 2 weeks to less than 1 month 3 1–3 months 4 More than 3 months					
b.	What was the total amount paid for these coverages in 1996? <i>Include union and member contributions</i> .	C3.						
196	¢ 00		that included July 1, 1996 for ALL hospital and physician plans that you offered at this location .					
	\$.00	199	Include union and member contributions.					
			\$.00					

Page 4 FORM MEPS-12 (7-7-97)

		S	ection D -	UNION	CHARA	CTERISTIC	S	
D1.	Enter the number of r period on the label fo 1996. If you offered number of members of through your union.	r the period that health insura	it included Ju nce , also ente	ıly 1, er the	D3.	Through colle any of these Check all that		your union offer
a.	All members				050	Paid vac		
		FI: 11.	- "		051 052	Paid sick		
200	Total 201	Eligible	Enroll	ed	053	Life insu Disability		
					054		ent/pension plans	
b.	Were retirees eligible July 1, 1996?	to receive heal	th insurance	on	055 056	☐ Medical :	Savings Accounts (MS spending accounts	SAs)
219	1 ☐ Yes – Check all th	nat apply —	2 🗌 No		057	☐ Cafeteria	a plan –	
			2 L. 110			Enter the	e average	
		under 65 years 65 years and o	/er			annual v member	alue per	.00
D2.	For the period that inc		996 -		D4.	If your union total membe	has members at mul rship for all the location	tiple locations, enter the ons.
a.	Enter the number of v members				034		al annulus albertation of	Harada
b.	Enter the number of r 50 years old or older	nembers	039			Ll lot	al membership for all	locations
	Enter the number of n	nombore who e	arnad					
0.	Litter the number of t	ilellibers wild e	042					
	(1) Less than \$6.50 p	er hour	L					
	(0)		043					
	(2) Between \$6.50 ar	nd \$15.00 per h	our					
	(3) More than \$15.00	per hour						
500 Rem	arks				•			
	Section E - PERSON COMPLETING THIS QUESTIONNAIRE							
²¹² Nam	e (Please print)				²¹³ Title			
Signatur	·e							²¹⁴ Date
o.g.iatai	•							5410
215 T '	hana maraka s	220 🗖 🔭	216 [4]	-			217 - 1 1 - 3 1	1
∠ i≎ Telep /	ohone number	²²⁰ Extension	FAX nun ا	noer			²¹⁷ E-Mail address	
١	ı		\ /					

FORM **MEPS-12(P)**

U.S. DEPARTMENT OF COMMERCE BUREAU OF THE CENSUS ACTING AS COLLECTING AGENT FOR U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

MEDICAL EXPENDITURE PANEL SURVEY (INSURANCE COMPONENT)

PERSON-LEVEL QUESTIONNAIRE FOR UNIONS

Collection of this information is authorized under Title IX, Section 902(a) of the Public Health Service Act. Sections 903(c) and 308(d) of that Act specify that all information will be held in strict confidence by the staff of the Agency for Health Care Policy and Research and their authorized contractors.

RETURN TO Bureau of the Census 1201 East 10th Street Jeffersonville, IN 47132-0001

If you have any questions concerning this survey, please call 1–888–273–3878.

A FEW IMPORTANT INSTRUCTIONS AND DEFINITIONS

- 1. In this questionnaire, "this person" refers to the individual named in the label area. A permission slip signed by the individual authorizing our collection of this information is included at the back of this reporting package.
- 2. "Your organization" refers to the location on the label of this questionnaire.
- 3. For this survey, a health insurance plan is defined as providing hospital and/or physician coverage for a single premium to members and/or retirees. Also included in Section C of this questionnaire are single-service plans, which provide optional coverage not included in the basic health insurance plan(s) for an additional premium.

	an additional premium.
	Section A - PERSON-LEVEL INFORMATION
A1.	Which category below best describes this person's status with your union on July 1, 1996?
065	1 A full- or part-time member 2 A retired member 3 A former member 4 A relative/survivor of a former member 8 No record of this person – Go to Section D on page 3.

	Section B - HOSPITAL	OR PH	YSICIAN PLAN
B1a.	Was this person eligible for hospital/physician insurance coverage through your union on July 1, 1996?	B4b.	How much did this person contribute towards his/her coverage?
350	1 ☐ Yes 2 ☐ No – If No, go to Section C on page 3. If more than one plan was offered through this union, answer Part b below. If only one plan	362	Report for the same premium period as in Question B4a. \$.00
b.	Of the hospital/physician plans offered by your union, for which plans was this person eligible?	353	OR Percent of insurance premium
	Please enter plan name(s) exactly as entered in Question B1 of the Union Questionnaire (MEPS-12) or Supplemental Sheet (MEPS-12(S)).	C.	How much did your union contribute towards this person's coverage?
351 501	□ All OR ≠	363	Report for the same premium period as in Question B4a.
502			\$.00 OR
503		354	Percent of insurance premium
504		d.	How much did sources other than your union, such as a government or employer, contribute towards/subsidize this person's coverage?
	Was this person enrolled in a hospital/physician plan provided by your union on July 1, 1996?		Report for the same premium period as in Question B4a.
231	1 \square Yes \nearrow 2 \square No – If No, go to Section C on page 3. If more than one plan was offered through this	355	\$.00
_	union, answer Part b below. If only one plan was offered, go to Question B3.	356	OR
b.	In which hospital/physician plan(s) was this person enrolled? Please enter plan name(s) exactly as entered in Question B1		Percent of insurance premium OR
352	of the Union Questionnaire (MEPS-12) or Supplemental Sheet (MEPS-12(S)).	357	□ No subsidy/contribution from other sources – Go to Section C on page 3.
021	∐ All OR ⊋		
505		B5.	What was the source of the outside subsidy or contribution reported in B4d?
ВЗ.	What level of coverage did this person choose?	358	Check only ONE.
239	1 Single 3 One adult/one child 2 Two adults 4 Family (3 or more people)		2 ☐ Government 4 ☐ Employer 3 ☐ Other
B4.	For the pay period including July 1, 1996, provide the information below regarding premiums paid for this person's hospital/physician coverage.		
a.	What was the total premium including union and member contributions?		
	If this plan was self-insured, enter the monthly premium equivalent.		
361	\$.00 PER → 2 □ 2 weeks 3 □ Month 4 □ Year		

Page 2 FORM MEPS-12(P) (7-8-97)

Control No.

	Section C - SINGL	E-SERV	/ICE PLANS
C1.	On July 1, 1996, did this person obtain through your union any optional coverage (not included in his/her basic health plan reported in Section B above) at an additional premium?	C3a.	What was the total premium for all single-service plans obtained by this person, including union and member contributions?
246 	1 ☐ Yes 2 ☐ No − If No, go to Section D. Which of the following single-service plans did this	_	\$.00 PER -> 2 \(\to 2 \) weeks 3 \(\to Month \) 4 \(\to Year \)
370	person obtain? Check all that apply. Dental	b.	How much did this person contribute towards his/her single-service plan coverage? Report for the same premium period as in Question C3a.
372 371 373	☐ Vision☐ Prescription drugs☐ Long-term care	375	\$.00 OR
			Percent of insurance premium
500 Ren	narks		
	Section D - PERSON COMPL	ETING '	THIS OHESTIONNAIDE
²¹² Nan	ne (Please print)	²¹³ Title	
Signatu	ire		²¹⁴ Date
²¹⁵ Tele	ephone number 220 Extension 216 FAX number ()		²¹⁷ E-Mail address

FORM MEPS-12(P) (7-8-97) Page 3

FORM **MEPS-12(S)** (7-8-97)

U.S. DEPARTMENT OF COMMERCE BUREAU OF THE CENSUS ACTING AS COLLECTING AGENT FOR U.S. DEPARTMENT OF HEALTH AND HIMAN SERVICES

HEALTH AND HUMAN SERVICES			
MEDICAL EXPENDITURE PANEL SURVEY (INSURANCE COMPONENT)			
	SUPPLEMENTAL SHEET UNION QUESTIONNAIRE		
		CTIONS	
use	is Supplemental Sheet is a reprint of the questions in Se e it to report additional health plan information. You ma pies were not included in your reporting package. Refer estionnaire (MEPS-12) when completing this Suppleme	y use phot to the inst	tocopies of this Supplemental Sheet if sufficient tructions on the first page of the Union
	Section B – PLAN (CHARAC	TERISTICS
B1.	Enter the name of the health insurance plan and the insurance carrier.	_	or self-insured plans only:
	FOR CENSUS USE ONLY	B5a. In	dicate if you administered the plan or if you employed a ird party.
100			Self-administered Insurance company or other administrator
⁰¹² Nam	e of plan	b. Di	d you purchase stop-loss coverage?
¹⁰² Nam	ne of insurance carrier	. ¹⁰⁷ 1	☐ Yes 2 ☐ No
		C. E	nter this union's total annual cost of coverage for this
B2.	Indicate the type of providers in this plan.	cl	an for the plan year that included July 1, 1996. Include: aims paid, administrative costs, and stop-loss coverage fany). Include union and member contributions.
103	1 Exclusive providers – Enrollees must go to providers associated with the plan except in an emergency. There is typically no cost or a small fixed cost for each physician visit. (For example, HMOs, IPAs, EPOs)	108	.00
	2 Any providers – Enrollees can go to the physicians of their choice on a fee-for-service basis. The plan does not have any associated providers. (For example, conventional plans, indemnity plans)	fa co O	nter the monthly premium equivalents for single and amily (of four) coverage for a typical member. Include the ests entered in B5c. Also enter this information in uestion B9a (single) and B9b (family) – Total premium on age 2.
	3 Mixture of preferred and any providers – Enrollees can go to a set of "preferred" providers associated with the plan, or providers of their choice. If they go to a non-preferred provider, they face higher costs. (For example, PPOs, POSs)	109	Single coverage
В3.	Did this plan require that the enrollee see a primary-care physician in order to be referred to a specialist?		Family coverage
104	1 ☐ Yes 2 ☐ No	to	id any enrollee receive a direct subsidy or contribution wards any part of the premium (e.g., from a government remployer)?
B4.	Indicate the type of indemnification of this plan.		1 ☐ Yes 2 ☐ No
105	Purchased from an insurance underwriter – Coverage is purchased from an insurance company or other underwriter who assumes the risk for enrollees' medical expenses.		what month did the plan year begin?
	If purchased, go to Question B6.		nter a numeric response e.g., Jan = 01, May = 05).
	2 Self-insured – Your union pays the claims from its resources and may charge a premium to members. The plan may be administered by a <i>third party</i> . This type may employ supplemental <i>stop-loss insurance</i> to limit unanticipated losses.		ig, ca – v i, may – voj.

	Section B – PLAN CHARA	CTERIS	TICS - Continued
B8a.	For this plan, enter the total number of enrollees excluding dependents for this union on July 1, 1996.	B10b.	Did the amount of the member contribution (not premium) vary for different member categories (e.g.,
124		143	full-time, part-time, senority, work site, occupation)? 1 ☐ Yes 2 ☐ No
b.	Enter the total number of active members enrolled.	B11.	Did this plan's premium include either of these services?
125			Check all that apply.
		144	☐ Life insurance 145 ☐ Disability insurance
C.	Enter the number of retirees enrolled.		
127	Total 65 and older	B12.	Enter the annual deductibles that enrollees paid out of their pockets before the plan began paying for covered services (using the plan's providers). Many HMO-type plans do not have deductibles.
	Enter the total number of enrollees with single coverage.	146	Total individual
129			\$ annual deductible OR $ otag$
			Separate deductibles for:
B 9a.	Enter this plan's total premium, union contribution, and member contribution for an enrollee with single		\$.00 Physician care
	coverage.		148
	If self-insured, enter the monthly premium equivalent from Question B5d on page 1.		\$.00 Hospital care If the deductible is per overnight hospital stay,
130	Trom Question Bod on page 1.		report under B13a.
	\$.00 Total premium	149	Total family annual
131	\$.00 Heigh contribution		deductible (if applicable)
132	\$.00 Union contribution	150	Number of persons – Enter if the plan also specified that the family deductible was met
132	\$.00 Member contribution		when a number of family members fulfilled their individual deductibles.
	Indicate the premium period 🖟	151	Plan did not have a deductible
133	1 Week 2 2 2 weeks 3 Month 4 Year		
b.	Enter this plan's total premium, union contribution, and member contribution for an enrolled family (of four).	B13a.	How much did an enrollee pay for an overnight hospital stay (in a participating hospital, if applicable) after any annual deductible was met?
	Report for the same premium period as Question B9a.	152	\$.00 Per day
	If self-insured, enter the monthly premium equivalent		S 2 Per stay
134	from Question B5d on page 1.	153	
	\$.00 Total premium		Percent
135	6 00	155	OR
136	\$.00 Union contribution	133	☐ Hospital care was not covered
150	\$.00 Member contribution	b.	How much did an enrollee pay for an office visit (with a participating physician, if applicable) after any annual
137	☐ Family coverage was not offered		deductible was met?
R100	Did the proprietors (not contributions) your by	156	¢ 00
BIVa.	Did the premiums (not contributions) vary by –		\$.00
	Check all that apply.	157	OR
138 139	☐ Age? ☐ Sex?		Percent
140	☐ Number of persons (within family coverage)?		OR
142	Other? - Specify	218	☐ Physician care was not covered
099			

Page 2 FORM MEPS-12(S) (7-8-97)

	Section B – PLAN CHARACTERISTICS – Continued					
B14.	What was the maximum amount this plan would have paid for an individual –	B17.	Could this plan have refused to cover persons with certain preexisting conditions?			
a.	Over the enrollee's lifetime?	183	1 ☐ Yes ⊋ 2 ☐ No			
159	\$.00		Did this happen in 1996?			
b.	In one year?	184	1 ☐ Yes 2 ☐ No			
160	\$.00	B18.	Could this plan have imposed a waiting period for			
158	☐ No maximum		persons with certain preexisting conditions?			
		185	1 ☐ Yes 2 ☐ No			
B15.	What was the maximum annual out-of-pocket amount for –	<u> </u>				
a.	An individual?	B19a.	Is this plan offered in 1997?			
161	\$.00	186	1 ☐ Yes – If Yes, go to Question B19c. 2 ☐ No			
L.			2 LI NO			
D. 162	A family (of four)?	b.	If it is not still offered, indicate if it has been –			
	\$.00	187	1 ☐ Replaced with a similar plan			
163	☐ No maximum		2 Replaced by a substantially different plan			
B16.	Indicate which of these services were included in the plan.		3 ☐ Dropped without offering a replacement – END THIS FORM.			
	Check all that apply.					
164	☐ Routine mammograms	C.	For 1997, enter the single and family enrollments and			
165	Adult routine physical exams		premiums for this plan or the one that took its place. Report for the same premium period as in Question B9a			
166	Routine pap smears		on page 2.			
167	Office visits for prenatal care	188				
168 169	Adult immunizations	189	Single enrollment			
	☐ Child immunizations		Family enrollment			
170 171	☐ Well-baby care, under 1 year☐ Well-child care, 1–4 years	190				
172	100% well-baby care	101	\$.00 Single premium			
173	☐ Chiropractic care	191	\$.00 Family premium			
174 175	☐ Other non-physician providers ☐ Outpatient prescriptions		, ·			
176						
177	☐ Routine dental care ☐ Orthodontic care					
178	☐ Nursing home care					
179	Home health care					
180	☐ Inpatient mental illness					
181 182	Outpatient mental illness					
,02	Alcohol/substance abuse treatment					
500 Remai	ks					

FORM **MEPS-13** (7-8-97)

U.S. DEPARTMENT OF COMMERCE BUREAU OF THE CENSUS ACTING AS COLLECTING AGENT FOR U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

MEDICAL EXPENDITURE PANEL SURVEY (INSURANCE COMPONENT)

SELF-EMPLOYED QUESTIONNAIRE

Collection of this information is authorized under Title IX, Section 902(a) of the Public Health Service Act. Your report to the Census Bureau is **confidential** by law (Title 13, United States Code). It may be seen only by sworn Census employees and may be used only for statistical purposes.

RETURN |

Bureau of the Census 1201 East 10th Street Jeffersonville, IN 47132-0001

If you have any questions concerning this survey, please call 1–888–273–3878.

Please correct errors in name, address, and ZIP Code. ENTER number and street if not shown.

A FEW IMPORTANT INSTRUCTIONS AND DEFINITIONS

- 1. For this survey, a health insurance plan is defined as providing hospital and/or physician coverage for a single premium to the enrollee. Exclude extra-cash plans (a specified number of dollars per day in the hospital) or dread-disease (e.g., cancer-only) plans.
- 2. Section C requests information on plans providing coverage for a single service, such as dental, drug, or vision coverage, at an additional cost.
- 3. Estimates are acceptable if you do not have this information readily available.
- 4. Provide information for the **period that included July 1, 1996**. However, **annual** costs should be reported for **calendar year 1996**, if possible, or for the plan year that included July 1, 1996.

Section A - HEALTH INSURANCE INFORMATION

		· · · · · · · · · · · · · · · · · · ·	
A 1.	On July 1, 1996, did you operate a business or profession that produced self-employment income, with no paid employees other than yourself?	A3a.	Were you covered by a private health insurance plan(s) that covered hospital and/or physician services on July 1, 1996?
225	1 \square Yes 2 \square No – If No, go to Section E on page 4.	231	1 ☐ Yes 2 ☐ No – If No, go to Section C on page 3.
A2a.	Were you covered by a public health insurance plan on July 1, 1996? 1 Yes 2 No – If No, go to Question A3a. Indicate the type(s) of public health insurance by which you were covered on July 1, 1996. Check all that apply. Medicaid	232 233 234 235	Which of these categories best describes how you obtained (each of) your health insurance plans? Check all that apply. From your current or former spouse's employer plan From your current or previous employer From an insurance carrier or HMO From a union
228	☐ Medicare	236	☐ From a trade/ professional association
229	☐ CHAMPUS/CHAMPVA	237	From a pooling arrangement Complete
230	Other public health insurance		(e.g., a small business group) Section B on page 2.
		238	☐ Other – Specify 🔀
		098	

	Section B - PLAN CHARACTERISTICS					
	Provide information for the hospital and/or physician plan(s) in which you were enrolled on July 1, 1996 . Exclude any plan(s) in which you may have been covered through your or your spouse's current or former employer. If you have more than one hospital and/or physician plan, please make a copy of Section B and complete it for each plan.					
B1.	What was the name of the health insurance plan and its carrier, covering hospital and/or physician services, in which you were enrolled on July 1, 1996?	B7.	pocke	the annual deductibles required out of your et before the plan began paying for covered ces (using the plan's providers). Many -type plans do not have deductibles.		
	FOR CENSUS USE ONLY	146	\$	Total individual		
100				.00 annual deductible OR Separate deductibles for:		
			147			
⁰¹² Nam	e of plan			\$.00 Physician care		
			148	\$.00 Hospital care		
¹⁰² Nam	e of insurance carrier			If the deductible is per overnight hospital stay,		
		149		report under B8a.		
B2.	Indicate the type of providers in this plan.	140	\$.00 Total family annual deductible (If applicable)		
103	1 ☐ Exclusive providers – Enrollees must go to	150		Number of persons – Enter if the plan also specified that the family deductible was met		
	providers associated with the plan except in an emergency. There is typically no cost or a small		when a number of family members fulfil their individual deductibles.			
	fixed cost for each physician visit. (For example, HMOs, IPAs, EPOs)	151	□ Pla	an did not have a deductible		
	2 Any providers – Enrollees can go to the physicians of their choice on a fee-for-service basis. The plan	B8a.	How hosp	much would you have paid for an overnight ital stay (in a participating hospital, if applicable)		
	does not have any associated providers. (For example, conventional plans, indemnity plans)	152	after	any annual deductible was met?		
	3 ☐ Mixture of preferred and any providers –	152	\$.00 → 154 1 ☐ Per day 2 ☐ Per stay		
	Enrollees can go to a set of "preferred" providers associated with the plan, or providers of their			OR		
	choice. If they go to a non-preferred provider, they face higher costs. (For example, PPOs, POSs)	153		Percent		
				OR		
B3.	Did this plan require that you see a primary-care physician in order to be referred to a specialist?	155	□⊦	lospital care was not covered		
104	1	b.	How	much would you have paid for an office visit		
				a participating physician, if applicable) after any al deductible was met?		
B4.	Indicate the level of coverage purchased:	156	_	00		
239	1 ☐ Single 2 ☐ Two adults		\$.00 OR		
	3 ☐ One adult/one child	157				
	4 Family (3 or more people)			Percent		
B5.	What was the total premium paid for this hospital and/or	218		OR		
004	physician plan?		- L -	Physician care was not covered		
361	$\begin{array}{c} & & & \\ \$ & & .00 \end{array} \longrightarrow \begin{array}{c} 376 & 3 \square \text{ Monthly} \\ 4 \square \text{ Yearly} \end{array}$	B9.	What	was the maximum amount this plan would have		
	5 🗌 Quarterly	a.		your lifetime?		
	6 ☐ Semi-annually	159				
	Didwy was in a disease which		\$.00		
B6.	Did you receive a direct subsidy or contribution towards this plan's premium from another source, such as a	b.	In on	e year?		
	government?	160	\$.00		
122	1 ☐ Yes 2 ☐ No	158		No maximum		

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Control No.

Section B – HEALTH INSURANCE PLAN INFORMATION – Continued							
B10.	What was the maximum annual out-of-pocket amount you could have paid?	B12.	Could this plan have imposed a waiting period for persons with certain preexisting conditions?				
241	\$.00	185	1 ☐ Yes 2 ☐ No 3 ☐ Don't know				
163	☐ No maximum						
B11.	Indicate which of these services were included in the plan. Check all that apply.	B13a.	Are you currently enrolled in the same health plan this year?				
164 165 166 167 168 169 170 171	Routine mammograms Adult routine physical exams Routine pap smears Office visits for prenatal care Adult immunizations Child immunizations Well-baby care, under 1 year Well-child care, 1–4 years 100% well-baby care	243	1 ☐ Yes - If Yes, go to Question B13c. 2 ☐ No What type of health plan replaced the one you had in 1996? 1 ☐ Similar plan 2 ☐ Substantially different plan 3 ☐ No longer purchase a health plan - Go to Section C. What is your 1997 premium for this plan or the one that				
173 174 175 176 177 178 179 180 181	☐ Chiropractic care ☐ Other non-physician providers ☐ Outpatient prescriptions ☐ Routine dental care ☐ Orthodontic care ☐ Nursing home care ☐ Home health care ☐ Inpatient mental illness ☐ Outpatient mental illness ☐ Alcohol/substance abuse treatment	244	took its place? \$.00 245 3 Monthly 4 Yearly 5 Quarterly 6 Semi-annually				
	Section C - SINGLE-SERV	ICE PLA	N INFORMATION				
C1.	Did you obtain any optional single-service coverage (not included in your basic hospital and/or physician coverage) at an additional premium? 1 Yes 2 No – If No, go to Section D on page 4.	C3.	What was the total premium paid for your single-service plan(s)? \$.00 3 Monthly 4 Yearly 5 Quarterly 6 Semi-annually				
	Which of the following single-service plans did you purchase? Check all that apply. Dental Vision Prescription drugs Long-term care						

	Section D – SELF-EMPLOYMENT INFORMATION				
D1.	How long have you operated this business/profession?	D2.	Which of these categories best describes your principal business activity (i.e., generates MOST of your revenue)?		
064	Years	060	Check only ONE. 1 Retail (sell to general public) 2 Personal services (e.g., beauty shops, dry cleaners) 3 Business services (e.g., advertising, computer processing) 4 Other services (e.g., legal and health services) 5 Manufacturing 6 Wholesale trade (sell to businesses and industry) 7 Finance, insurance, or real estate 8 Transportation, communications, electric, gas, or sanitary services 9 Construction 10 Agriculture or forestry		
	Section E – DEMOGR				
	Unless otherwise directed, please answer the following July 1, 1996. The following characteristics of busines	g demog s owners	graphic questions as they pertained to you on save being used for statistical purposes only.		
E1.	What is your sex? 1 ☐ Male 2 ☐ Female	E5.	Including yourself and your spouse, how many dependents do you have?		
E2.			Number of dependents		
249	1 Under 24 4 4 45-54	E6a.	Are you of Hispanic, Latino, or Spanish origin?		
	2 24-34	258	1 ☐ Yes 2 ☐ No		
E3. 250	What is the highest level of education you have obtained? 1 Some high school 2 High school degree or G.E.D. 3 Some college 4 Undergraduate/Bachelor's degree (B.S., B.A., etc.) 5 Graduate studies	259	Which group best represents your race? Check only ONE. 1 American Indian 4 Black 2 Aleut, Eskimo 5 White 3 Asian or Pacific Islander 6 Other		
E4.	What is your marital status?	E7.	What was your 1996 annual household income? (Household income for all family members after business expenses.)		
251	1 ☐ Single, never married 4 ☐ Separated 2 ☐ Married, spouse employed 5 ☐ Divorced 3 ☐ Married, spouse not employed 6 ☐ Widowed	260	1 Under \$25,000 4 \$75,000 - \$99,999 2 \$25,000 - \$44,999 5 \$100,000 and over 3 \$45,000 - \$74,999		
500 Rema	arks				
Section F - PERSON COMPLETING THIS QUESTIONNAIRE					
²¹² Name	e (Please print)	²¹³ Title			
Signatur	e		214 Date		
215 T alar	phone number 220 Extension 216 FAX number		217 E-Mail address		
() ()		E Man address		

FORM **MEPS-14(P)**

U.S. DEPARTMENT OF COMMERCE BUREAU OF THE CENSUS ACTING AS COLLECTING AGENT FOR U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

MEDICAL EXPENDITURE PANEL SURVEY (INSURANCE COMPONENT)

INSURANCE PROVIDER QUESTIONNAIRE

Collection of this information is authorized under Title IX, Section 902(a) of the Public Health Service Act. Sections 903(c) and 308(d) of that Act specify that all information will be held in strict confidence by the staff of the Agency for Health Care Policy and Research and their authorized contractors.

RETURN TO

Bureau of the Census 1201 East 10th Street Jeffersonville, IN 47132-0001

If you have any questions concerning this survey, please call 1–888–273–3878.

Please correct errors in name, address, and ZIP Code. ENTER street and number if not shown.

A FEW IMPORTANT INSTRUCTIONS AND DEFINITIONS

- 1. For this survey, a health insurance plan is defined as providing hospital and/or physician coverage for a single premium to the enrollee.
- 2. Section C requests information on plans providing coverage for a single service, such as dental, drug, or vision coverage, at an additional cost.
- 3. Estimates are acceptable if you do not have this information readily available.
- 4. Provide information for the period that included July 1, 1996. However, annual costs should be reported for calendar year 1996, if possible, or for the plan year that included July 1, 1996.

	Section A – HEALTH INSURANCE INFORMATION						
A1.	Did this company provide health insurance coverage on July 1, 1996, to the person named in the label area of this questionnaire? 1 Yes 2 No - If No, go to Section D on page 3.	A2b.	Did your company provide a single-service plan to this person? 1 Yes – If Yes, go to Section C on page 3. 2 No				
A2a.	Did your company provide a hospital and/or physician plan (including Medigap) to this person? 1 Yes - If Yes, go to Section B on page 2. 2 No	G.	Did your company provide a dread-disease or extra-cash plan to this person? 1 Yes - If Yes, go to Section D on page 3. 2 No - If No, go to Section B on page 2.				

	Section B - PLAN CHARACTERISTICS						
	Please provide information for the plan in which the person named in the label was enrolled on July 1, 1996. Answer the questions only for the hospital/physician insurance plan which covered a set of benefits (including hospital stays and /or physician visits) for a single premium. Additional benefits such as dental, vision, or prescription drugs may be included in these plans.						
B1.	What was the name of the plan in which this person was enrolled on July 1, 1996? e of plan	B6. 361	What was this plan's premium for this person? \$.00				
	Was this a Medigap plan?	B7.	6 Semi-annually				
275 b. 276	1 ☐ Yes 2 ☐ No − If No, go to Question B3. Which of the 10 common plans, identified by letters "A–J", is this Medigap plan?	239	1 Single 2 Two adults 3 One adult, one child 4 Family (3 or more people)				
277	OR Not applicable	B8.	Was there a waiting period for this person before his/her plan benefits began? 1 ☐ Yes 2 ☐ No				
C. 278	Is the premium for this Medigap plan issue-age rated or attained-age rated? 1 Issue-age rated 2 Attained-age rated 3 Neither	B9a. 291 b.	Was a summary of this person's recent health history required for enrollment in this plan? 1 ☐ Yes 2 ☐ No Was a physical examination required for enrollment				
B3.	Was this person's enrollment financed through Medicare or Medicaid?	292	in this plan? 1 ☐ Yes 2 ☐ No				
	1 Medicare 2 Medicaid 3 Neither	B10a.	Is this plan community rated? 1 Yes No - If No, go to Question B11 on page 3.				
B4a.	For the period including July 1, 1996, was this person's plan a group policy? 1 ☐ Yes 2 ☐ No	b.	How is this plan rated? Check all that apply.				
b. 281	How many policyholders were in the group?	294 295 296	☐ Age☐ Geographic area☐ Other☐ Other☐ Go to Question B12a on page 3.				
B5.	What type of plan did your company provide to this person? Check only ONE.						
282	Conventional Health Insurance (Fee-for-Service) PPO (Preferred Provider Organization) HMO (Health Maintenance Organization) PPO (Exclusive Provider Organization) POS/Open Ended HMO (Point of Service)						
097	6 ☐ Other – Specify						

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Control No.

		Sectio	n B – PLAN CHA	RACTERIS	TICS- Cor	ntinued	
297 298 299 300 301 302 303	For this plan, which caffected the premium Check all that apply. Age Health enhancing Smoking Other health ence Geographic area Specific medical Other	n amount? g habits langering habit conditions	s/hobbies	304 b. 305 306 307 308 309	Which of the enrollment in Check all that ☐ Age ☐ Smoking ☐ Other he ☐ Specific ☐ Other	2 □ No - If No, go e following characterism in this plan? at apply. go ealth endangering hat medical conditions	stics precluded
			Section C - SIN	GLE-SERV	CE PLANS		
C1.	Did your company provide to	on at an addition	onal premium? Section D.	C3. 374	What was th single-service	e total premium this pee plan(s)?	person paid for his/her 3
370 371 372 373	Check all that apply. Dental Prescription drug Vision Long-term care			C4.	1 Single 2 Two add 3 One add		erson hold?
500 Remarks							
		Section D	- PERSON COM	PLETING T	HIS QUES	TIONNAIRE	
²¹² Name	e (Please print)			²¹³ Title			
Signatur	е			1			214 Date
²¹⁵ Telep (hone number)	²²⁰ Extension	²¹⁶ FAX number ()			²¹⁷ E-Mail address	